CELTIC INSURANCE COMPANY

Home Office: 233 South Wacker Drive, Chicago, Illinois 60606-6393
1-800-477-7870

Major Medical Expense Insurance Policy

This policy is in effect from the effective date stated on the Schedule of Benefits through 12-31-2014.

In this *policy, "you"* or *"your"* will refer to the *covered person* named on the Schedule of Benefits, and *"we," "our,"* or *"us"* will refer to Celtic Insurance Company.

AGREEMENT AND CONSIDERATION

We issued this *policy* in consideration of the application and the payment of the first premium. A copy of *your* application is attached and is made a part of the *policy*. *We* will pay benefits to *you*, the *covered person*, for covered *loss* due to *illness* or bodily *injury* as outlined in this *policy*. Benefits are subject to *policy* definitions, provisions, limitations and exclusions.

GUARANTEED RENEWABLE

You may keep this *policy* in force by timely payment of the required premiums. However, *we* may refuse renewal if: (1) *we* refuse to renew all policies issued on this form, with the same type and level of benefits, to residents of the state where *you* then live; or (2) there is fraud or a material misrepresentation made by or with the knowledge of a *covered person* for *policy* benefits.

From time to time, *we* will change the rate table used for this *policy* form. Each premium will be based on the rate table in effect on that premium's due date. The policy plan, and age of *covered persons,* type and level of benefits, and place of residence on the premium due date are some of the factors used in determining *your* premium rates. We have the right to change premiums.

At least 31 days notice of any plan to take an action or make a change permitted by this clause will be delivered to *you* at *your* last address as shown in *our* records. *We* will make no change in *your* premium solely because of claims made under this *policy* or a change in a *covered person's* health. While this *policy* is in force, *we* will not restrict coverage already in force.

As a cost containment feature, this policy contains prior authorization requirements. Please refer to the Schedule of Benefits and the Prior Authorization Section.

TEN DAY RIGHT TO RETURN POLICY

Please read your *policy* carefully. If you are not satisfied, return this *policy* to us or to our agent within 10 days after you receive it. All premiums paid will be refunded, less claims paid, and the *policy* will be considered null and void from the effective date.

Celtic Insurance Company

Anand Shukla
SVP, Individual Health – Celtic Insurance Company

TABLE OF CONTENTS

DEFINITIONS

In this policy, italicized words are defined. Words not italicized will be given their ordinary meaning.

Wherever used in this policy:

Acute rehabilitation means two or more different types of therapy provided by one or more rehabilitation medical practitioners and performed for three or more hours per day, five to seven days per week, while the covered person is confined as an inpatient in a hospital, *rehabilitation facility*, or *skilled nursing facility*.

Adverse benefit determination means:

1. Any claim denial, reduction, or termination of, or a failure to provide, or make payment in whole or in part for a benefit, including:
    a. Deductible credits; coinsurance; network provider reductions or exclusions,;
    b. Any instance where the plan pays less than the total expenses submitted resulting in claimant responsibility;
    c. A benefit resulting from the application of any utilization review;
    d. A covered benefit that is otherwise denied as not medically necessary or appropriate;
    e. A covered benefit that is otherwise denied as experimental or investigational;
2. Any denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's eligibility to participate in the plan, including any decision to deny coverage at the time of application; and
3. Any *rescission* of coverage whether or not the *rescission* has an adverse effect on any particular benefit at that time.
4. Any denial to provide benefits for a *medically necessary* drug when (1) the drug is not included in a drug formulary used by this health plan and (2) *your physician* or authorized prescriber has determined the drug is *medically necessary*.

Regarding the independent review procedures, this includes the denial of a request for a referral for out-of-network services when the claimant requests health care services from a provider that does not participate in the provider network because the clinical expertise of the provider may be medically necessary for treatment of the claimant's medical condition and that expertise is not available in the provider network.

Allogeneic bone marrow transplant or ***BMT*** means a procedure in which bone marrow from a related or non-related donor is infused into the transplant recipient and includes peripheral blood stem cell transplants.

Ambulatory surgical center means an establishment with an organized medical staff of physicians, with permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures, with continuous physician services and registered professional nursing services available whenever a patient is in the facility, which does not provide services or other accommodations for patients to stay overnight, and which offers the following services whenever a patient is in the center:

1) Drug services as needed for medical operations and procedures performed.
2) Provisions for physical and emotional well-being of patients.
3) Provision of emergency services.

4) Organized administrative structure.
5) Administrative, statistical and medical records.
6) Operated primarily for the purpose of offering stereotactic radiosurgery by use of a Gamma Knife or similar neurosurgical tool.

Autologous bone marrow transplant or ***ABMT*** means a procedure in which the bone marrow infused is derived from the same person who is the transplant recipient and includes peripheral blood stem cell transplants.

Beneficiary means a person designated by a participant, or by the terms of a health insurance benefit plan, who is or may become entitled to a benefit under the plan.

Bereavement counseling means counseling of members of a deceased person's *immediate family* that is designed to aid them in adjusting to the person's death.

Calendar Year is the period beginning on the initial effective date of this policy and ending December 31 of that year. For each following year it is the period from January 1 through December 31.

Center of Excellence means a *hospital* that:
1. Specializes in a specific type or types of *listed transplants* or other services such as cancer, bariatric or infertility; and
2. Has agreed with *us* or an entity designated by *us* to meet quality of care criteria on a cost efficient basis. The fact that a *hospital* is a *network provider* does not mean it is a *Center of Excellence.*

Clinical Trial means investigational treatments and associated protocol-related patient care when all of the following criteria are met:
1. The treatment is being provided with a therapeutic or palliative intent for patients with cancer or other life threatening condition, or for the prevention or early detection of cancer or other life threatening condition.
2. The treatment in relation to the prevention and detection of cancer or other life-threatening disease or condition is being provided or the studies are being conducted in a Phase I, Phase II, Phase III, or Phase IV clinical trial.
3. The treatment is being provided in accordance with a clinical trial approved by one of the following entities:
    a. One of the United States NIH.
    b. A cooperative group funded by one of the NIH.
    c. The FDA in the form of an investigational new drug application.
    d. The United States Department of Veterans Affairs.
    e. The United States Department of Defense.
    f. A federally funded general clinical research center.
    g. The Coalition of National Cancer Cooperative Groups.

Coinsurance is the percentage of *covered expenses* that must be paid by *you* after the *deductible.* This percentage is shown on the Schedule of Benefits.

Coinsurance percentage means the percentage of *covered expenses* that are payable by *us*.

Complaint means any expression of dissatisfaction expressed to the insurer by the claimant, or a claimant's authorized representative, about an insurer or its providers with whom the insurer has a direct or indirect contract.

Complications of pregnancy means:

1. Conditions whose diagnoses are distinct from pregnancy, but are adversely affected by pregnancy or are caused by pregnancy and not, from a medical viewpoint, associated with a normal pregnancy. This includes: ectopic pregnancy, spontaneous abortion, eclampsia, missed abortion, and similar medical and surgical conditions of comparable severity; but it does not include: false labor, preeclampsia, edema, prolonged labor, physician prescribed rest during the period of pregnancy, morning sickness, and conditions of comparable severity associated with management of a difficult pregnancy, and not constituting a medically classifiable distinct complication of pregnancy; and
2. An *emergency* caesarean section or a *non-elective caesarean section*.

Continuous loss means that *covered expenses* are continuously and routinely being incurred for the active treatment of an *illness* or *injury*. The first *covered expense* for the *illness* or *injury* must have been incurred before insurance of the *covered person* ceased under this *policy*. Whether or not *covered expenses* are being incurred for the active treatment of the covered *illness* or *injury* will be determined by *us* based on generally accepted current medical practice.

Cosmetic treatment means treatments, procedures, or services that change or improve appearance without significantly improving physiological function and without regard to any asserted improvement to the psychological consequences or socially avoidant behavior resulting from an *injury*, *illness*, or congenital anomaly.

Covered expense means an expense that is:

1. Incurred while *your* or *your dependent's* insurance is in force under this *policy*;
2. Covered by a specific benefit provision of this *policy*; and
3. Not excluded anywhere in this *policy*.

Covered person means *you*, *your* lawful *spouse* and each *eligible child*:

1. Named in the application; or
2. Whom *we* agree in writing to add as a *covered person*.

Custodial Care is treatment designed to assist a *covered person* with activities of daily living and which can be provided by a layperson and not necessarily aimed at curing or assisting in recovery from a sickness or bodily injury.

Custodial care includes but is not limited to the following:

1. Personal care such as assistance in walking, getting in and out of bed, dressing, bathing, feeding and use of toilet;
2. Preparation and administration of special diets;
3. Supervision of the administration of medication by a caregiver;
4. Supervision of self-administration of medication; or

5. Programs and therapies involving or described as, but not limited to, convalescent care, rest care, sanatoria care, educational care or recreational care.

Such treatment is custodial regardless of who orders, prescribes or provides the treatment.

Deductible amount means the amount of *covered expenses*, shown in the *Schedule of Benefits*, that must actually be paid during any calendar year before any benefits are payable. The family *deductible amount* is two times the individual *deductible amount*. For family coverage, once a *covered person* has met the individual *deductible amount*, the remainder of the family *deductible amount* can be met with the combination of any one or more covered persons' *eligible expenses*.

Dental expenses means *surgery* or services provided to diagnose, prevent, or correct any ailments or defects of the teeth and supporting tissue and any related supplies or oral appliances. Expenses for such treatment are considered *dental expenses* regardless of the reason for the services.

Dependent means *your* lawful *spouse* and/or an *eligible child*.

Durable medical equipment means items that are used to serve a specific diagnostic or therapeutic purpose in the treatment of an *illness* or *injury*, can withstand repeated use, are generally not useful to a person in the absence of *illness* or *injury*, and are appropriate for use in the patient's home.

Effective date means the applicable date a *covered person* becomes insured for *illness* or *injury*. The applicable *effective date* is shown:
1. In the Schedule of Benefits of this *policy* for initial *covered persons*; and
2. On the rider adding any new *covered person*.

Eligible child means *your* or *your spouse's* child, if that child is less than 26 years of age. As used in this definition, "child" means:
1. A natural child;
2. A grandchild who is in the legal custody of and residing with *you*;
3. A legally adopted child;
4. A child placed with *you* for adoption; or
5. A child placed with *you* following execution of the act of voluntary surrender which is in *your* favor and on the effective date on which the act of voluntary surrender becomes irrevocable; or
6. A child for whom legal guardianship has been awarded to *you* or *your spouse*. It is *your* responsibility to notify *us* if *your* child ceases to be an *eligible child*. *You* must reimburse *us* for any benefits that *we* pay for a child at a time when the child did not qualify as an *eligible child*.

Eligible expense means a *covered expense* as determined below.
1. For *network providers* excluding Transplant Benefits: When a *covered expense* is received from a *network provider*, the *eligible expense* is the contracted fee with that provider.
2. For non-*network providers*:
    a. When a *covered expense* is received from a non-*network provider* as a result of an *emergency* or as otherwise approved by *us*, the *eligible expense* is the lesser of the billed charge or a lower amount negotiated with the provider.

b. When a *covered expense* is received from a non-*network provider* because the service or supply is not of a type provided by any *network provider*, the *eligible expense* is the lesser of the billed charge or a lower amount negotiated with the provider; and
c. Except as provided under (1) and (2) above, when a *covered expense* excluding Transplant Benefits is received from a non-*network provider*, the *eligible expense* is determined based on the lesser of/the first of the following rules that can be applied in the order shown below:
    i. The fee that has been negotiated with the provider;
    ii. 110% of the fee Medicare allows for the same or similar services provided in the same geographical area;
    iii. The fee established by *us* by comparing rates from one or more regional or national databases or schedules for the same or similar services from a geographical area determined by *us*;
    iv. The fee charged by the provider for the services; or
    v. A fee schedule that *we* develop.

Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity including severe pain which requires immediate no later than 24 hours after onset medical or surgical care and such that an average person who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Placing the health of the *covered person* or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Emergency Medical Services means those medical services necessary to screen, evaluate, and stabilize an emergency medical condition.

Essential Health Benefits provided within this Policy are not subject to lifetime or annual dollar maximums. Certain non-essential health benefits, however, are subject to either a lifetime and/or annual dollar maximum. Essential Health Benefits are defined by federal law and refer to benefits in at least the following categories: Ambulatory patient services, Emergency services, Hospitalization, Maternity and newborn care, Mental health and substance use disorder services, including behavioral health treatment, Prescription drugs, Rehabilitative and habilitative services and devices, Laboratory services, Preventive and wellness services, and Chronic disease management and pediatric services, including oral and vision care.

Expedited grievance means a *grievance* where any of the following applies:

1. The duration of the standard resolution process will result in serious jeopardy to the life or health of the *claimant* or the ability of the claimant to regain maximum function;
2. In the opinion of a physician with knowledge of the claimant's medical condition, the claimant is subject to severe pain that cannot be adequately managed without the care or treatment that is the subject of the *grievance*; and
3. A physician with knowledge of the claimant's medical condition determines that the *grievance* shall be treated as an *expedited grievance*.

Experimental or ***investigational treatment*** means medical, surgical, diagnostic, or other health care services, treatments, procedures, technologies, supplies, devices, drug therapies, or medications that, after consultation with a medical professional, *we* determine to be:

1. Under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration (*USFDA*) regulation, regardless of whether the trial is subject to *USFDA* oversight;
2. An *unproven service;*
3. Subject to *USFDA* approval, and:
    a. It does not have *USFDA* approval;
    b. It has *USFDA* approval only under its Treatment Investigational New Drug regulation or a similar regulation;
    c. It has *USFDA* approval, but is being used for an indication or at a dosage that is not an accepted off-label use. An accepted off-label use of a *USFDA*-approved drug is a use that is determined by *us* to be:
        i. Included in authoritative compendia as identified from time to time by the Secretary of Health and Human Services;
        ii. Safe and effective for the proposed use based on supportive clinical evidence in peer-reviewed medical publications; or
        iii. Not an *unproven service;* or
    d. It has *USFDA* approval, but is being used for a use, or to treat a condition, that is not listed on the Premarket Approval issued by the *USFDA* or has not been determined through peer reviewed medical literature to treat the medical condition of the *covered person.*
4. Experimental or investigational according to the provider's research protocols.

Items (3) and (4) above do not apply to phase III or IV *USFDA* clinical trials.

Generally accepted standards of medical practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials.

If no credible scientific evidence is available, then standards that are based on physician specialty society recommendations or professional standards of care may be considered. *We* reserve the right to consult medical professionals in determining whether a health care service, supply, or drug is *medically necessary* and is a *covered expense* under the *policy*. The decision to apply physician specialty society recommendations, the choice of medical professional, and the determination of when to use any such opinion, will be determined by *us*.

Grievance means any dissatisfaction with an insurer offering a health benefit plan or administration of a health benefit plan by the insurer that is expressed in writing in any form to the insurer by, or on behalf of, an claimant including any of the following:

1. Provision of services;
2. Determination to reform or rescind a policy;
3. Determination of a diagnosis or level of service required for evidence-based treatment of Autism Spectrum Disorders (ASD); and
4. Claims practices.

Habilitation means ongoing, *medically necessary*, therapies provided to patients with developmental disabilities and similar conditions who need habilitation therapies to achieve functions and skills never

before acquired, including services and devices that improve, maintain, and lessen the deterioration of a patient's functional status over a lifetime and on a treatment continuum.

Home health aide services means those services provided by a home health aide employed by a *home health care agency* and supervised by a registered nurse, which are directed toward the personal care of a *covered person.*

Home health care means care or treatment of an *illness* or *injury* at the *covered person's* home that is:

1. Provided by a *home health care agency*; and
2. Prescribed and supervised by a *physician*.

Home health care agency means a public or private agency, or one of its subdivisions, that:

1. Operates pursuant to law as a *home health care agency*;
2. Is regularly engaged in providing *home health care* under the regular supervision of a registered nurse;
3. Maintains a daily medical record on each patient; and
4. Provides each patient with a planned program of observation and treatment by a *physician,* in accordance with existing standards of medical practice for the *injury* or *illness* requiring the *home health care.*

Hospice means an institution that:

1. Provides a *hospice care program*;
2. Is separated from or operated as a separate unit of a *hospital, hospital*-related institution, *home health care agency,* mental health facility, *skilled nursing facility,* or any other licensed health care institution;
3. Provides care for the *terminally ill;* and
4. Is licensed by the state in which it operates.

Hospice care program means a coordinated, interdisciplinary program prescribed and supervised by a *physician* to meet the special physical, psychological, and social needs of a *terminally ill covered person* and those of his or her *immediate family.*

Hospital means an institution that:

1. Operates as a *hospital* pursuant to law;
2. Operates primarily for the reception, care, and treatment of sick or injured persons as *inpatients*;
3. Provides 24-hour nursing service by registered nurses on duty or call;
4. Has staff of one or more *physicians* available at all times;
5. Provides organized facilities and equipment for diagnosis and treatment of acute medical, surgical, or mental conditions either on its premises or in facilities available to it on a prearranged basis; and
6. Is not primarily a long-term care facility; an *skilled nursing facility*, nursing, rest, *custodial care*, or convalescent home; a halfway house, transitional facility, or *residential treatment facility;* a place for the aged, drug addicts, alcoholics, or runaways; a facility for wilderness or outdoor programs; or a similar establishment.

While confined in a separate identifiable *hospital* unit, section, or ward used primarily as a nursing, rest, *custodial care* or convalescent home, *rehabilitation facility*, *skilled nursing facility,* or *residential treatment*

facility, halfway house, or transitional facility, a *covered person* will be deemed not to be confined in a *hospital* for purposes of this *policy*.

Illness means a sickness, disease, or disorder of a *covered person*. *Illness* does not include learning disabilities, attitudinal disorders, or disciplinary problems. All *illnesses* that exist at the same time and that are due to the same or related causes are deemed to be one *illness*. Further, if an *illness* is due to causes that are the same as, or related to, the causes of a prior *illness*, the *illness* will be deemed a continuation or recurrence of the prior *illness* and not a separate *illness*.

Immediate family means the parents, *spouse*, children, or siblings of any *covered person*, or any person residing with a *covered person*.

Injury means accidental bodily damage sustained by a *covered person* and inflicted on the body by an external force. All *injuries* due to the same accident are deemed to be one *injury*.

Inpatient means that medical services, supplies, or treatment are received by a person who is an overnight resident patient of a *hospital* or other facility, using and being charged for room and board.

Intensive care unit means a Cardiac Care Unit, or other unit or area of a *hospital*, that meets the required standards of the Joint Commission on Accreditation of Hospitals for Special Care Units.

Intensive day rehabilitation means two or more different types of therapy provided by one or more *rehabilitation medical practitioners* and performed for three or more hours per day, five to seven days per week.

Loss means an event for which benefits are payable under this *policy*. A *loss* must occur while the *covered person* is insured under this *policy*.

Life-threatening condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Listed transplant means one of the following procedures and no others:

1. Heart transplants;
2. Lung transplants;
3. Heart/lung transplants;
4. Kidney transplants;
5. Liver transplants;
6. Hematopoietic cell transplantation when the following conditions are met:
    a. The transplant center is certified by the Federation for the Accreditation of Hematopoietic Cell Therapy (FAHCT) or by at least one of the following National Institutes of Health sponsored cooperative groups: the Southwest Oncology Group (SWOG), the Eastern Cooperative Oncology Group (ECOG), or the Cancer and Leukemia Group B (CALGB), for adult patients; and the Pediatric Oncology Group (POG) or Children's Cancer Group (CCG) for pediatric patients.
    b. The transplant center accepts payment at the same rate paid to other transplant centers located outside of Louisiana with whom the health insurance issuer has a contract for such services.

c. The transplant center agrees to perform all medically necessary services associated with hematopoietic cell transplantation at no additional cost to the insured or enrollee regardless of any lifetime benefit limits or other limitations on coverage.

7. Solid Human Organ Transplants of the Pancreas, small bowel and other solid organ transplant procedures, determined to be effective procedures by peer review literature as well as other sources used to evaluate new procedures. These solid organ transplants will be considered on a case-by-case basis.
8. The following tissue transplant:
    a. Blood Transfusions;
    b. Autologous parathyroid transplants;
    c. Corneal transplants;
    d. Bone and cartilage grafting;
    e. Skin grafting;
    f. Autologous islet cell transplants; and
    g. Other tissue transplant procedures, determined to be effective procedures by peer review literature as well as other sources used to evaluate new procedures. These tissue transplants will be considered on a case-by-case basis.
9. Bone marrow transplants for the following conditions:
    a. *BMT* or *ABMT* for Non-Hodgkin's Lymphoma;
    b. *BMT* or *ABMT* for Hodgkin's Lymphoma;
    c. *BMT* for Severe Aplastic Anemia;
    d. *BMT* or *ABMT* for Acute Lymphocytic and Nonlymphocytic Leukemia;
    e. *BMT* for Chronic Myelogenous Leukemia;
    f. *ABMT* for Testicular Cancer;
    g. *BMT* for Severe Combined Immunodeficiency;
    h. *BMT* or *ABMT* for Stage III or IV Neuroblastoma;
    i. *BMT* for Myelodysplastic Syndrome;
    j. *BMT* for Wiskott-Aldrich Syndrome;
    k. *BMT* for Thalassemia Major;
    l. *BMT* or *ABMT* for Multiple Myeloma;
    m. *ABMT* for pediatric Ewing's sarcoma and related primitive neuroectodermal tumors, Wilm's tumor, rhabomyosarcoma, medulloblastoma, astrocytoma and glioma;
    n. *BMT* for Fanconi's anemia;
    o. *BMT* for malignant histiocytic disorders; and
    p. Allogeneic, autologous and syngeneic bone marrow transplants, including tandem transplants, mini transplants (transplant lite) and donor lymphocyte transfusions.
    q. *BMT* for juvenile.

Loss of Minimum essential coverage means in the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions are satisfied at the time the coverage is terminated as a result of loss of eligibility regardless of whether the individual is eligible for or elects COBRA continuation coverage. Loss of eligibility does not include a loss due to the failure of the employee or dependent to pay premiums on a timely basis or termination of coverage for cause such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan. Loss of eligibility for coverage includes, but is not limited to:

1. Loss of eligibility for coverage as a result of legal separation, divorce, cessation of dependent status such as attaining the maximum age to be eligible as a dependent child under the plan, death of an

employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;
2. In the case of coverage offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area whether or not within the choice of the individual;
3. In the case of coverage offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area whether or not within the choice of the individual, and no other benefit package is available to the individual;
4. A situation in which a plan no longer offers any benefits to the class of similarly situated individuals as described in § 54.9802-1(d) that includes the individual;
5. In the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions are satisfied at the time employer contributions towards the employee's or dependent's coverage terminate. Employer contributions include contributions by any current or former employer that was contributing to coverage for the employee or dependent, and
6. In the case of an employee or dependent who has coverage that is COBRA continuation coverage, the conditions are satisfied at the time the COBRA continuation coverage is exhausted. An individual who satisfies the conditions for special enrollment, does not enroll, and instead elects and exhausts COBRA continuation coverage satisfies the conditions.

Managed drug limitations means limits in coverage based upon time period, amount or dose of a drug, or other specified predetermined criteria.

Manipulative Therapy means treatment applied to the spine or joint structures to correct vertebral or joint malposition and to eliminate or alleviate somatic dysfunction including, but not limited to, manipulation, myofacial release or soft tissue mobilization. Treatment must demonstrate pain relief and continued improvement in range of motion and function and cannot be performed for maintenance care only. *Manipulative therapy* is not limited to treatment by manual means.

Maximum therapeutic benefit means the point in the course of treatment where no further improvement in a *covered person's* medical condition can be expected, even though there may be fluctuations in levels of pain and function.

Medical practitioner means a *physician*, nurse anesthetist, physician's assistant, physical therapist, or midwife. The following are examples of providers that are NOT *medical practitioners*, by definition of the *policy:* acupuncturist, speech therapist, occupational therapist, rolfer, registered nurse, hypnotist, respiratory therapist, X-ray technician, *emergency* medical technician, social worker, family counselor, marriage counselor, child counselor, naturopath, perfusionist, massage therapist or sociologist. With regard to medical services provided to a *covered person*, a *medical practitioner* must be licensed or certified by the state in which care is rendered and performing services within the scope of that license or certification.

Medically necessary or ***medical necessity*** means any medical service, supply or treatment authorized by a *physician* to diagnose and treat a *covered person 's illness or injury* which:
1. Is consistent with the symptoms or diagnosis;
2. Is provided according to generally accepted medical practice standards;

3. Is not *custodial care*;
4. Is not solely for the convenience of the *physician* or the *covered person*;
5. Is not *experimental or investigational*;
6. Is provided in the most cost effective care facility or setting;
7. Does not exceed the scope, duration, or intensity of that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment; and
8. When specifically applied to a *hospital* confinement, it means that the diagnosis and treatment of *your* medical symptoms or conditions cannot be safely provided as an outpatient.

Charges incurred for treatment not *medically necessary* are not *eligible expenses*.

Medically stabilized means that the person is no longer experiencing further deterioration as a result of a prior *injury* or *illness* and there are no acute changes in physical findings, laboratory results, or radiologic results that necessitate acute medical care. Acute medical care does not include *acute rehabilitation*.

Medicare opt-out practitioner means a *medical practitioner* who:
1. Has filed an affidavit with the Department of Health and Human Services stating that he, she, or it will not submit any claims to Medicare during a two-year period; and
2. Has been designated by the Secretary of that Department as a *Medicare opt-out practitioner*.

Medicare participating practitioner means a *medical practitioner* who is eligible to receive reimbursement from Medicare for treating Medicare-eligible individuals.

Mental disorder is a behavioral, emotional or cognitive pattern of functioning in an individual that is associated with distress, suffering, or impairment in one or more areas of life – such as school, work, or social and family interactions

Necessary medical supplies means medical supplies that are:
1. Necessary to the care or treatment of an *injury* or *illness*;
2. Not reusable or *durable medical equipment*; and
3. Not able to be used by others.

Necessary medical supplies do not include first aid supplies, cotton balls, rubbing alcohol, or like items routinely found in the home.

Network means a group of *physicians* and providers who have contracts that include an agreed upon price for health care expenses.

Network eligible expense means the *eligible expense* for services or supplies that are provided by a *network provider*. For facility services, this is the *eligible expense* that is provided at and billed by a *network* facility for the services of either a *network* or non-*network provider*. *Network eligible expense* includes benefits for *emergency* health services even if provided by a non-*network provider*.

Network provider means a *physician* or provider who is identified in the most current list for the *network* shown on *your* identification card.

Newly born means infants from the time of birth until age one month or until such time as the infant is well enough to be discharged from a hospital or neonatal special care unit to his home, whichever period is longer.

Non-elective caesarean section means:
1. A caesarean section where vaginal delivery is not a medically viable option; or
2. A repeat caesarean section.

Non-network provider means a *physician* or provider who is NOT identified in the most current list for the *network* shown on *your* identification card. Services received from a *non-network provider* are not covered, except as specifically stated in this policy.

Non-network eligible expense means the *eligible expense* for services or supplies that are provided and billed by a non-*network provider.*

Out-of-pocket expenses means those expenses that a *covered person* is required to pay that: (A) qualify as *covered expenses*; and (B) are not paid or payable if a claim were made under any *other plan*.

Outpatient surgical facility means any facility with a medical staff of *physicians* that operates pursuant to law for the purpose of performing *surgical procedures*, and that does not provide accommodations for patients to stay overnight. This does not include facilities such as: acute-care clinics, *urgent care centers*, ambulatory-care clinics, free-standing emergency facilities, and *physician* offices.

Pain management program means a program using interdisciplinary teams providing coordinated, goal-oriented services to a *covered person* who has chronic pain that significantly interferes with physical, psychosocial, and vocational functioning, for the purpose of reducing pain, improving function, and decreasing dependence on the health care system. A *pain management program* must be individualized and provide physical *rehabilitation*, education on pain, relaxation training, and medical evaluation.

Period of extended loss means a period of consecutive days:
1. Beginning with the first day on which a *covered person* is a *hospital inpatient;* and
2. Ending with the 30th consecutive day for which he or she is not a *hospital inpatient.*

Physician means a licensed medical practitioner who is practicing within the scope of his or her licensed authority (including chiropractors, podiatrists, optometrists, and psychologists) in treating a bodily injury or sickness and is required to be covered by state law. A *physician* does **NOT** include someone who is related to a *covered person* by blood, marriage or adoption or who is normally a member of the *covered person's* household.

Placement for adoption, in connection with any placement for adoption of a child with any person, means the assumption and retention by such person of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's placement with such person terminates upon the termination of such legal obligation.

Policy when *italicized,* means this *policy* issued and delivered to *you*. It includes the attached pages, the applications, and any amendments.

Post-service claim means any claim for benefits for medical care or treatment that is not a *pre-service claim*.

Pre-service claim means any claim for benefits for medical care or treatment that requires the approval of the plan in advance of the claimant obtaining the medical care.

Pregnancy means the physical condition of being pregnant, but does not include *complications of pregnancy*.

Prescription drug means any medicinal substance whose label is required to bear the legend "RX only."

Prescription order means the request for each separate drug or medication by a *physician* or each authorized refill or such requests.

Proof of loss means information required by *us* to decide if a claim is payable and the amount that is payable. It includes, but is not limited to, claim forms, medical bills or records, other plan information, and *network* re-pricing information. *Proof of loss* must include a copy of all Explanation of Benefit forms from any other carrier, including Medicare.

Reconstructive surgery means *surgery* performed on an abnormal body structure caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease in order to improve function or to improve the patient's appearance, to the extent possible.

Rehabilitation means care for restoration including by education or training of one's prior ability to function at a level of *maximum therapeutic benefit*. This type of care must be *acute rehabilitation*, *sub-acute rehabilitation*, or *intensive day rehabilitation*, and it includes *rehabilitation therapy* and *pain management programs*. An *inpatient* hospitalization will be deemed to be for *rehabilitation* at the time the patient has been *medically stabilized* and begins to receive *rehabilitation therapy* or treatment under a *pain management program*.

Rehabilitation facility means an institution or a separate identifiable *hospital* unit, section, or ward that:

1. Is licensed by the state as a *rehabilitation facility*; and
2. Operates primarily to provide 24-hour primary care or *rehabilitation* of sick or injured persons as *inpatients*.

Rehabilitation facility does not include a facility primarily for rest, the aged, long term care, assisted living, *custodial care,* nursing care*,* or for care of the mentally incompetent.

Rehabilitation medical practitioner means a *physician*, physical therapist, speech therapist, occupational therapist, or respiratory therapist. A *rehabilitation medical practitioner* must be licensed or certified by the state in which care is rendered and performing services within the scope of that license or certification.

Rehabilitation therapy means physical therapy, occupational therapy, speech therapy, or respiratory therapy.

Rescission of a policy means a determination by an insurer to withdraw the coverage back to the initial date of coverage.

Residence means the physical location where *you* live. If *you* live in more than one location, and *you* file a United States income tax return, the physical address, not a P.O. Box, shown on *your* United States income tax return as *your* residence will be deemed to be *your* place of residence. If *you* do not file a United States income tax return, the *residence* where *you* spend the greatest amount of time will be deemed to be *your* place of *residence*.

Residential treatment facility means a facility that provides, with or without charge sleeping accommodations, and:

1. Is not a *hospital, skilled nursing facility,* or *rehabilitation facility;* or
2. Is a unit whose beds are not licensed at a level equal to or more acute than skilled nursing.

Respite care means home health care services provided temporarily to a *covered person* in order to provide relief to the *covered person's immediate family* or other caregiver.

Skilled Nursing facility means an institution, or a distinct part of an institution, that:

1. Is licensed as a *hospital*, *skilled nursing facility*, or *rehabilitation facility* by the state in which it operates;
2. Is regularly engaged in providing 24-hour skilled nursing care under the regular supervision of a *physician* and the direct supervision of a registered nurse;
3. Maintains a daily record on each patient;
4. Has an effective utilization review plan;
5. Provides each patient with a planned program of observation prescribed by a *physician;* and
6. Provides each patient with active treatment of an *illness* or *injury*, in accordance with existing standards of medical practice for that condition.

Skilled nursing facility does not include a facility primarily for rest, the aged, treatment of *substance abuse, custodial care,* nursing care, or for care of *mental disorders* or the mentally incompetent.

Spouse means *your* lawful wife or husband.

Sub-acute rehabilitation means one or more different types of therapy provided by one or more *rehabilitation medical practitioners* and performed for one-half hour to two hours per day, five to seven days per week, while the *covered person* is confined as an *inpatient* in a *hospital*, *rehabilitation facility*, or *skilled nursing facility*.

Substance abuse means alcohol, drug or chemical abuse, overuse, or dependency.

Surgery or ***surgical procedure*** means:

1. An invasive diagnostic procedure; or
2. The treatment of a *covered person's illness* or *injury* by manual or instrumental operations, performed by a *physician* while the *covered person is under general or local anesthesia.*

Surveillance tests for ovarian cancer means annual screening using:

1. CA-125 serum tumor marker testing;
2. Transvaginal ultrasound; or
3. Pelvic examination.

Temporary medically disabled mother means a woman who has recently given birth and whose physician has advised that normal travel would be hazardous to her health.

Terminal illness counseling means counseling of the *immediate family* of a *terminally ill* person for the purpose of teaching the *immediate family* to care for and adjust to the *illness* and impending death of the *terminally ill* person.

Terminally ill means a *physician* has given a prognosis that a *covered person* has six months or less to live.

Third party means a person or other entity that is or may be obligated or liable to the *covered person* for payment of any of the *covered person's* expenses for *illness* or *injury*. The term *"third party"* includes, but is not limited to, an individual person; a for-profit or non-profit business entity or organization; a government agency or program; and an insurance company. However, the term *"third party"* will not include any insurance company with a policy under which the *covered person* is entitled to benefits as a named insured person or an insured *dependent* of a named insured person except in those jurisdictions where statutes or common law does not specifically prohibit *our* right to recover from these sources.

Tobacco use or ***use of tobacco*** means use of tobacco by individuals who may legally use tobacco under federal and state law on average four or more times per week and within no longer than the six months immediately preceding the date application for this *policy* was completed by the *covered person*, including all tobacco products but excluding religious and ceremonial uses of tobacco.

Unproven service(s) means services, including medications, that are determined not to be effective for treatment of the medical condition, and/or not to have a beneficial effect on health outcomes, due to insufficient and inadequate clinical evidence from *well-conducted randomized controlled trials* or *well-conducted cohort studies* in the prevailing published peer-reviewed medical literature.

1. *"Well-conducted randomized controlled trials"* means that two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received; and
2. *"Well-conducted cohort studies"* means patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.

Urgent care center means a facility, not including a *hospital emergency* room or a *physician's* office, that provides treatment or services that are required:

1. To prevent serious deterioration of a *covered person's* health; and
2. As a result of an unforeseen *illness, injury,* or the onset of acute or severe symptoms.

DEPENDENT COVERAGE

Dependent Eligibility
Your dependents become eligible for insurance on the latter of:

1. The date *you* became insured under this *policy;* or
2. The first day of the first full calendar month after the date of becoming *your dependent*.

Effective Date For Initial Dependents
The *effective date* for *your* initial *dependents,* if any, is shown on the Schedule of Benefits. Only *dependents* included in the application for this *policy* will be covered on *your effective date*.

Adding A Newborn Child
An *eligible child* born to *you* or *your spouse* will be covered from the time of birth until the 31st day after its birth. The newborn child will be covered from the time of its birth for *loss* due to *injury* and *illness*, including *loss* from complications of birth, premature birth, medically diagnosed congenital defect(s), and birth abnormalities.

Additional premium will be required to continue coverage beyond the 31st day after the date of birth of the child. The required premium will be calculated from the child's date of birth. Coverage of the child will terminate on the 31st day after its birth, unless *we* have received both: (A) written notice of the child's birth; and (B) the required premium within 90 days of the child's birth.

Adding An Adopted Child
An *eligible child* legally placed for adoption with *you* or *your spouse* will be covered from the date of *placement* until the 31st day after *placement,* unless the *placement* is disrupted prior to legal adoption and the child is removed from *your* or *your spouse's* custody.

The child will be covered for *loss* due to *injury* and *illness*, including *medically necessary* care and treatment of conditions existing prior to the date of *placement.*

Additional premium will be required to continue coverage beyond the 31st day following *placement* of the child. The required premium will be calculated from the date of *placement* for adoption. Coverage of the child will terminate on the 31st day following *placement*, unless *we* have received both: (A) written notice of *your* or *your spouse's* intent to adopt the child; and (B) any additional premium required for the addition of the child within 90 days of the date of *placement.*

As used in this provision, *"placement"* means the earlier of:

1. The date that *you* or *your spouse* assume physical custody of the child for the purpose of adoption; or
2. The date of entry of an order granting *you* or *your spouse* custody of the child for the purpose of adoption.

Adding Other Dependents
If *you* apply in writing for insurance on a *dependent* and *you* pay the required premiums, then the *effective date* will be shown in the written notice to *you* that the *dependent* is insured.

ONGOING ELIGIBILITY

For All Covered Persons
A *covered person's* eligibility for insurance under this *policy* will cease on the earlier of:

1. The date that a *covered person* accepts any direct or indirect contribution or reimbursement, by or on behalf of an employer, for any portion of the premium for coverage under this *policy*; or
2. The date a *covered person's* employer and a *covered person* treat this *policy* as part of an employer-provided health plan for any purpose, including tax purposes.

For Dependents
A *dependent* will cease to be a *covered person* at the end of the premium period in which he or she ceases to be *your dependent* due to divorce or if a child ceases to be an *eligible child*.

We must receive notification within 90 days of the date an insured ceases to be an eligible *dependent*. If notice is received by *us* more than 90 days from this date, any unearned premium will be credited only from the first day of the calendar month in which *we* receive the notice.

A *covered person* will not cease to be a *dependent eligible child* solely because of age if the *eligible child* is:

1. Not capable of self-sustaining employment due to mental handicap or physical handicap that began before the age limit was reached; and
2. Mainly dependent on *you* for support.

Open Enrollment
There will be an open enrollment period for coverage. The initial open enrollment period begins October 1, 2013 and extends through March 31, 2014. *Individuals* who enroll prior to December 15, 2013 will have an effective date of coverage on January 1, 2014. *Individuals* that enroll between the first and fifteenth day of any subsequent month during the initial open enrollment period, will have a coverage effective date of the first day of the following month. *Individuals* that enroll between the sixteenth and last day of the month between December 2013 and March 31, 2014, will have a coverage effective date of the first day of the second following month.

For years beginning on or after January 1, 2015, the annual open enrollment period begins October 15 and extends through December 7 of the preceding calendar year. *Individuals* who enroll prior to December 7, 2013 will have an effective date of coverage on January 1st of the following year.

Starting in 2014, *we* will send written annual open enrollment notification to each *covered person* no earlier than September 1st, and no later than September 30th.

Special And Limited Enrollment
An *individual* has 60 days to enroll as a result of one of the following events:

1. An *individual* or *dependent loses minimum essential coverage*;
2. An *individual* gains a dependent or becomes a *dependent* through marriage, birth, adoption or *placement* for adoption;
3. An individual who was not previously a citizen, national, or lawfully present individual gains such status;
4. An individual's enrollment or non-enrollment in a health plan is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an agent;

5. An *individual* or enrollee gains access to new health plans as a result of a permanent move;
6. Qualifying events as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended; or
7. With respect to individuals enrolled in non-calendar year health insurance policies, a limited open enrollment period beginning on the date that is 30 calendar days prior to the date the policy year ends in 2014.

PREMIUMS

Premium Payment
Each premium is to be paid to *us* on or before its due date. A due date is the last day of the period for which the preceding premium was paid.

Grace Period
After the first premium is paid, a grace period of 31 days from the premium due date is given for the payment of premium. Coverage will remain in force during the grace period. If payment of premium is not received within fifteen days prior to the end of the grace period, *we* will mail, by first class mail, a notice to *you*. The notice will state that if the premium has not been paid by the end of the grace period, the policy will lapse as provided by the provisions of the policy. The notice will also state that the policy will be reinstated with no penalties to the insured if the full premium payment is received within the period allowed for reinstatement.

Misstatement Of Age
If a *covered person's* age has been misstated, the benefits may be adjusted based on the relationship of the premium paid to the premium that should have been paid, based on the correct age.

Change Or Misstatement Of Residence
If *you* change *your residence*, *you* must notify *us* of *your* new *residence* within 60 days of the change. *Your* premium will be based on *your* new *residence* beginning on the first day of the next calendar month after the change. If *your residence* is misstated on *your* application, or *you* fail to notify *us* of a change of *residence*, *we* will apply the correct premium amount beginning on the first day of the first full calendar month *you* resided at that place of *residence*. If the change results in a lower premium, *we* will refund any excess premium. If the change results in a higher premium, *you* will owe *us* the additional premium.

Misstatement Of Tobacco Use
The answer to the tobacco question on the application is material to *our* correct underwriting. If a *covered person's use of tobacco* has been misstated on the *covered person's* application for coverage under this *policy, we* have the right to rerate the policy back to the original effective date.

Billing/Administrative Fees
Upon prior written notice, *we* may impose an administrative fee for credit card payments. This does not obligate *us* to accept credit card payments. *We* will charge a $20 fee for any check or automatic payment deduction that is returned unpaid.

MAJOR MEDICAL EXPENSE BENEFITS

Deductible
The *deductible amount* means the amount of *covered expenses* that must be paid by all *covered Persons* before any benefits are payable.

Coinsurance Percentage
We will pay the applicable *coinsurance percentage* in excess of the applicable deductible for a service or supply that:

1. Qualifies as a *covered expense* under one or more benefit provisions; and
2. Is received while the *covered person's* insurance is in force under the *policy* if the charge for the service or supply qualifies as an *eligible expense*.

When the annual out-of-pocket maximum has been met, additional *covered expenses* will be payable at 100%.

The amount payable will be subject to:

1. Any specific benefit limits stated in the *policy*;
2. A determination of *eligible expenses*; and
3. Any reduction for expenses incurred at a *non-network provider*. Please refer to the information on the Schedule of Benefits.

Note: The bill *you* receive for services or supplies from a *non-network provider* may be significantly higher than the *eligible expenses* for those services or supplies. In addition to the *deductible amount* and *coinsurance percentage*, *you* are responsible for the difference between the *eligible expense* and the amount the provider bills *you* for the services or supplies. Any amount *you* are obligated to pay to the provider in excess of the *eligible expense* will not apply to *your deductible amount* or out-of-pocket maximum.

Network Availability
Your network is subject to change upon advance written notice. A *network* may not be available in all areas. If *you* move to an area where *we* are not offering access to a *network*, the *network* provisions of the *policy* will no longer apply. In that event, benefits will be calculated based on the *eligible expense*, subject to the *deductible amount* for *network providers*. *You* will be notified of any increase in premium.

Coverage Under Other Policy Provisions
Charges for services and supplies that qualify as *covered expenses* under one benefit provision will not qualify as *covered expenses* under any other benefit provision of this *policy.*

Ambulance Service Benefits
Covered expenses will include ambulance services for:

1. Local transportation to the nearest *hospital* that can provide services appropriate to the *member's illness* or *injury*.
2. Transportation, including air or surface transport, of all the *newly born* to the nearest available hospital or neonatal special care unit for treatment of illnesses, injuries, congenital defects, and complications of premature birth.
3. Transportation by professional ambulance services of the *temporarily medically disabled mother* of the ill *newly born* when accompanying the ill *newly born* to the nearest available hospital or

neonatal special care unit. The mother's need for professional ambulance service must be certified by her attending physician.
4. Air ambulance services requested by police or medical authorities at the site of an *emergency*.
5. Air ambulance services for those situations in which the member is in a location that cannot be reached by ground ambulance.

Exclusions:
No benefits will be paid for:
1. Expenses incurred for ambulance services covered by a local governmental or municipal body, unless otherwise required by law;
2. Non-*emergency* air ambulance;
3. Air ambulance:
    a. Outside of the 50 United States and the District of Columbia;
    b. From a country or territory outside of the United States to a location within the 50 United States or the District of Columbia; or
    c. From a location within the 50 United States or the District of Columbia to a country or territory outside of the United States; or
4. Ambulance services provided for a *covered person's* comfort or convenience.

Mental Health and Substance Abuse Expense Benefits
Covered expenses for mental health and substance abuse are included on a non-discriminatory basis for all *covered persons* for the diagnosis and *medically necessary* and active treatment of mental, emotional, and substance use disorders, as described in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders. *Deductible* and treatment limits for behavioral health expense benefits will be applied in the same manner as physical health service benefits.

Covered expenses are included on a non-discriminatory basis for individuals seeking diagnosis and treatment for mental health disorders following any type of assault or violent act, including rape or an assault with intent to commit rape when the diagnosis and treatment costs exceed the maximum compensation allowed by the state.

Inpatient, intermediate and outpatient mental health and substance abuse service expenses are covered, if *medically necessary* and may be subject to prior authorization. See the Prior Authorization Section for more information regarding services that require prior authorization and the Schedule of Benefits for more information regarding specific benefit, day or visit limits, if any. Medication management visits do not require prior authorization for *network providers*.

Inpatient mental health and substance abuse *covered expenses* include the following**:** 24 hour services, delivered in a psychiatric unit of a licensed general hospital, a psychiatric hospital, or a substance abuse facility, that provide evaluation and treatment for an acute psychiatric condition or substance use diagnosis, or both.

Intermediate mental health and substance abuse *covered expenses* include the following**:** Non-inpatient services that provide more intensive and extensive treatment interventions when outpatient services alone are not sufficient to meet the patient's needs. Intermediate care is based on *medical necessity*.

Outpatient mental health and substance abuse *covered expenses* include the following**:** Services provided in person in an ambulatory care setting. Outpatient services may be provided in a licensed *hospital*, a mental health or substance abuse clinic licensed by the appropriate state entity, a public community mental health center, a professional office or home–based services. Such services delivered in such offices or settings are to be rendered by a licensed mental health professional, a licensed physician who specializes in the practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a licensed mental health counselor, or a licensed nurse mental health clinical specialist acting within the scope of his/her license.

Other *covered expenses* for mental health and substance abuse include:

1. Diagnosis and treatment of the following biologically based mental disorders: Schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder, delirium and dementia, affective disorders, eating disorders, post-traumatic stress disorder, substance abuse disorders; and
2. Autism Spectrum Disorder (ASD) ASD Benefits include, but are not limited to the *medically necessary* assessment, evaluations, or tests performed for diagnosis, habilitative or rehabilitative care, pharmacy care, psychiatric care, psychological care, and therapeutic care. Members who have not yet reached their seventeenth (17th) birthday are eligible for Applied Behavior Analysis, when *we* determine it is *medically necessary*. Applied Behavior Analysis is not covered for members seventeen (17) and older;
3. For children and adolescents under the age of 19:
    a. Treatment of non-biologically-based mental, behavioral, or emotional disorders which substantially interfere with or limit the functioning and social interactions of a child or adolescent. Benefits may be provided if the ongoing course of treatment is completed beyond age 19; and
    b. Mandated benefits beyond age 19 may be covered even if coverage continues under other benefit contracts.
4. Adult substance abuse residential treatment;
5. Clinically managed detoxification services in a substance abuse facility;
6. Partial hospitalization;
7. Intensive Outpatient Programs (IOP); and
8. Day treatment.

Habilitation, Rehabilitation And Skilled nursing Facility Expense Benefits

Covered expenses include expenses incurred for *habilitation* or *rehabilitation* services or confinement in an *skilled nursing facility*, subject to the following limitations:

1. *Covered expenses* available to a *covered person* while confined primarily to receive *habilitation* or *rehabilitation* are limited to those specified in this provision;
2. *Rehabilitation* services or confinement in a *rehabilitation facility* or *skilled nursing facility* must begin within 14 days of a *hospital* stay of at least 3 consecutive days and be for treatment of, or *rehabilitation* related to, the same *illness* or *injury* that resulted in the *hospital* stay;
3. *Covered expenses* for *provider facility* services are limited to charges made by a *hospital*, *rehabilitation facility*, or *skilled nursing facility* for:
    a. Daily room and board and nursing services;
    b. Diagnostic testing; and
    c. Drugs and medicines that are prescribed by a *physician*, must be filled by a licensed pharmacist, and are approved by the U.S. Food and Drug Administration;

4. *Covered expenses* for non-*provider facility* services are limited to charges incurred for the professional services of *rehabilitation medical practitioners.*

See the Schedule of Benefits for benefit levels or additional limits.

Care ceases to be *rehabilitation* upon *our* determination of any of the following:
1. The *covered person* has reached *maximum therapeutic benefit*;
2. Further treatment cannot restore bodily function beyond the level the *covered person* already possesses;
3. There is no measurable progress toward documented goals; and
4. Care is primarily *custodial care*.

Exclusion:
No benefits will be paid under these Habilitation, Rehabilitation and Skilled nursing Facility Expense Benefits for charges for services or confinement related to treatment or therapy for *mental disorders* or *substance abuse*.

Definition:
As used in this provision, *"provider facility"* means a *hospital, rehabilitation facility*, or *skilled nursing facility*.

Home Health Care Expense Benefits
Covered expenses for *home health care* are limited to the following charges:
1. *Home health aide services*;
2. Services of a private duty registered nurse rendered on an outpatient basis;
3. Professional fees of a licensed respiratory, physical, occupational, or speech therapist required for *home health care;*
4. I.V. medication and pain medication;
5. Hemodialysis, and for the processing and administration of blood or blood components;
6. *Necessary medical supplies*; and
7. Rental of the *durable medical equipment* set forth below:
    a. I.V. stand and I.V. tubing;
    b. Infusion pump or cassette;
    c. Portable commode;
    d. Patient lift;
    e. Bili-lights, and
    f. Suction machine and suction catheters.

Charges under (4) and (7) are *covered expenses* to the extent they would have been *covered expenses* during an *inpatient hospital* stay.

At *our* option, *we* may authorize the purchase of the equipment in lieu of its rental if the rental price is projected to exceed the equipment purchase price, but only from a provider *we* authorize before the purchase. If the equipment is purchased, the *covered person* must return the equipment to *us* when it is no longer in use.

An agency that is approved to provide *home health care* to those receiving Medicare benefits will be deemed to be a *home health care agency*.

Limitations:
Covered expenses for *home health aide services* will be limited to:
1. Seven visits per week; and
2. A calendar year maximum of 60 visits.

Each eight-hour period of *home health aide services* will be counted as one visit.

Covered expenses for outpatient private duty registered nurse services will be limited as follows:
1. Outpatient private duty registered nurse services will be limited to a lifetime maximum of 1,000 hours; and
2. Intermittent private duty registered nurse visits, not to exceed 4 hours each will be:
    a. Limited to $75 per visit; and
    b. Deemed to be 2 hours applied towards the hourly lifetime maximum above.

Exclusion:
No benefits will be payable for charges related to *respite care, custodial care,* or educational care.

Private Duty Nursing Services
Coverage is available to a *covered person* for Private Duty Nursing Services as shown in the Schedule of Benefits when performed on an Outpatient basis and when the nurse is not related to the *covered person* by blood, marriage or adoption.

Limitation:
Private Duty Nursing Services are covered at the Coinsurance level and are subject to the limitations shown in the Schedule of Benefits.

Exclusion:
No benefits will be provided for Inpatient Private Duty Nursing Services.

Hospice Care Expense Benefits
This provision only applies to a *terminally ill covered person* receiving *medically necessary* care under a *hospice care program*.

The list of *covered expenses* in the Miscellaneous Medical Expense Benefits provision is expanded to include:
1. Room and board in a *hospice* while the *covered person* is an *inpatient;*
2. Occupational therapy;
3. Speech-language therapy;
4. The rental of medical equipment while the *terminally ill covered person* is in a *hospice care program* to the extent that these items would have been covered under the *policy* if the *covered person* had been confined in a *hospital;*
5. Medical, palliative, and supportive care, and the procedures necessary for pain control and acute and chronic symptom management;
6. Counseling the *covered person* regarding his or her *terminal illness;*

7. *Terminal illness counseling* of members of the *covered person's immediate family, and*
8. Up to $250 for *bereavement counseling*.

Exclusions And Limitations:
Any exclusion or limitation contained in the *policy* regarding:
1. An *injury* or *illness* arising out of, or in the course of, employment for wage or profit;
2. Medical necessity of services or supplies, to the extent such services or supplies are provided as part of a *hospice care program;* or
3. Expenses for other persons, to the extent those expenses are described above, will not be applied to this provision.

Benefits for *hospice inpatient* or outpatient care are available to a *terminally ill covered person* for one continuous period up to 180 days in a *covered person's* lifetime. For each day the *covered person* is confined in a *hospice,* benefits for room and board will not exceed:
1. For a *hospice* that is associated with a *hospital* or nursing home, the most common semiprivate room rate of the *hospital* or nursing home with which the *hospice* is associated; or
2. For any other *hospice,* the lesser of the billed charge or $200 per day.

Miscellaneous Medical Expense Benefits
Medical *covered expenses* are limited to charges:
1. Made by a *hospital* for:
    a. Daily room and board and nursing services, not to exceed the *hospital's* most common semi-private room rate;
    b. Daily room and board and nursing services while confined in an *intensive care unit*.
    c. *Inpatient* use of an operating, treatment, or recovery room;
    d. Outpatient use of an operating, treatment, or recovery room for *surgery;*
    e. Services and supplies, including drugs and medicines, that are routinely provided by the *hospital* to persons for use only while they are *inpatients; and*
    f. *Emergency* treatment of an *injury* or *illness*, even if confinement is not required;
2. Made by an *ambulatory surgical center* provided the service would have been covered if performed as an *inpatient* service;
3. For services performed in an *urgent care center*;
4. For *surgery* in a *physician's* office or at an *outpatient surgical facility,* including services and supplies;
5. For Pre-admission testing;
6. For a second surgical opinion;
7. Made by a *physician* for professional services, including *surgery;*
8. Made by an assistant surgeon, limited to 20 percent of the *eligible expense* for the *surgical procedure;*
9. For the professional services of a *medical practitioner;*
10. For dressings, crutches, orthopedic splints, braces, casts, or other *necessary medical supplies;*
11. For diagnostic testing using radiologic, ultrasonographic, or laboratory services. Psychometric, behavioral and educational testing are not included;
12. For chemotherapy and radiation therapy or treatment;
13. For orally administered anti-cancer medications;
14. For hemodialysis, and the charges by a *hospital* for processing and administration of blood or blood components;

15. For the cost and administration of an anesthetic;
16. For oxygen and its administration;
17. For oral surgery benefits as follows:
    a. Excision of tumors or cysts (excluding odontogenic cysts) of the jaws, gums, cheeks, lips, tongue, roof and floor of mouth;
    b. Extraction of impacted teeth;
    c. Dental Care and Treatment including Surgery and dental appliances required to correct Accidental Injuries of the jaws, cheeks, lips, tongue, roof or floor of mouth, and of sound natural teeth. (For the purposes of this section, sound natural teeth include those, which are capped, crowned or attached by way of a crown or cap to a bridge. Sound natural teeth may have fillings or a root canal.);
    d. Excision of exostoses or tori of the jaws and hard palate;
    e. Incision and drainage of abscess and treatment of cellulitis;
    f. Incision of accessory sinuses, salivary glands, and salivary ducts;
    g. Anesthesia for the above services or procedures when rendered by an oral surgeon;
    h. Anesthesia for the above services or procedures when rendered by a dentist who holds all required permits or training to administer such anesthesia;
    i. Anesthesia when rendered in a Hospital setting and for associated Hospital charges when a Member's mental or physical condition requires dental treatment to be rendered in a Hospital setting. Anesthesia Benefits are not available for treatment rendered for temporomandibular joint (TMJ) disorders;
    j. Benefits are available for dental services not otherwise covered by this Benefit Plan, when specifically required for head and neck cancer patients. Benefits are limited to preparation for or follow-up to radiation therapy involving the mouth;
18. For reconstructive breast surgery charges as a result of a partial or total mastectomy for breast cancer. Coverage includes surgery and reconstruction of the diseased and non-diseased breast and prosthetic devices necessary to restore a symmetrical appearance and treatment in connection with other physical complications resulting from the mastectomy including lymphedemas;
19. For *medically necessary* services and supplies used in the treatment of diabetes*. Covered expenses* include, but are not limited to, exams including podiatric exams; routine foot care such as trimming of nails and corns; laboratory and radiological diagnostic testing; self-management equipment, and supplies such as urine and/or ketone strips, blood glucose monitor supplies, glucose strips for the device, and syringes or needles; orthotics and diabetic shoes; urinary protein/microalbumin and lipid profiles; educational health and nutritional counseling for self-management, eye examinations, and prescription medication;
20. For *medically necessary manipulative therapy* treatment on an outpatient basis only. See the Schedule of Benefits for benefit levels or additional limits. *Covered expenses* are subject to all other terms and conditions of the *policy,* including deductible and *coinsurance percentage* provisions;
21. For maternity care of the primary *covered person* or *spouse*: outpatient and inpatient pre- and post-partum care including exams, prenatal diagnosis of genetic disorder, laboratory and radiology diagnostic testing, health education, nutritional counseling, risk assessment, childbirth classes, and hospital stays for delivery or other *medically necessary* reasons less any applicable *deductible*, or *coinsurance*. An inpatient stay is covered for at least 48 hours following a vaginal delivery, and for at least 96 hours following a caesarean delivery. Other maternity benefits include *complications of pregnancy,* parent education, assistance, and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests;
22. For the following types of tissue transplants:

a. Cornea transplants;
b. Artery or vein grafts;
c. Heart valve grafts;
d. Prosthetic tissue replacement, including joint replacements; and
e. Implantable prosthetic lenses, in connection with cataracts;

23. Coverage for services performed by a qualified interpreter/ transliterator, other than a family member of the insured person, when such services are used by the insured person in connection with medical treatment or diagnostic consultations performed by a physician, provided such medical treatment or consultation is covered under the policy and provided the services are required because of a hearing impairment of the insured person or a failure of the insured person to understand or otherwise communicate in spoken language;
24. Coverage for treatment being provided in accordance with an approved *clinical trial* except any applicable copayment, deductible or coinsurance amounts;
25. For *medically necessary* sleep studies when obtained in a facility that is accredited by the Joint Commission or the American Academy of Sleep Medicine (AASM);
26. Coverage for Outpatient registered dietician visits;
27. For non-emergency care when traveling outside the United States;
28. For Routine Wellness Physical Examinations; and
29. For specialist visits.

Cleft Lip and Cleft Palate
We cover charges for benefits for cleft lip and cleft palate. Coverage shall also include secondary conditions and treatment attributable to the primary medical condition. Such benefits shall include, but not be limited to the following: 1) oral and facial surgery, surgical management and follow-up care; 2) prosthetic treatment such as obturators, speech appliances and feeding appliances; 3) orthodontic treatment and management; 4) preventive and restorative dentistry to insure good health and adequate dental structures for orthodontic treatment or prosthetic management or therapy; 5) speech-language evaluation and therapy; 6) audiological assessments and amplification devices; 7) otolaryngology treatment and management; 8) psychological assessment and counseling; and 9) genetic assessment and counseling for patient and parent.

Attention Deficit/Hyperactivity Disorder
We cover charges for diagnosis and treatment of attention deficit/hyperactivity disorder.

Medical Foods
We cover expenses for medically necessary low protein food products for the treatment of *inherited metabolic diseases*.

Inherited metabolic disease means a disease caused by an inherited abnormality of body chemistry. Such diseases are limited to: (a) Glutaric Acidemia; (b) Isovaleric Acidemia (IVA); (c) Maple Syrup Urine Disease (MSUD); (d) Methylmalonic Acidemia (MMA); (e) Phenylketonuria (PKU); (f) Propionic Acidemia; (g) Tyrosinemia; and (h) Urea Cycle Defects.

Miscellaneous Outpatient Medical Services and Supplies Expense Benefits
Covered expenses for miscellaneous outpatient medical services and supplies are limited to charges:

1. For artificial eyes or larynx, breast prosthesis, or basic artificial limbs but not the replacement thereof, unless required by a physical change in the *covered person* and the item cannot be

modified. If more than one prosthetic device can meet a *covered person's* functional needs, only the charge for the most cost effective prosthetic device will be considered a *covered expense*;
2. For one pair of foot orthotics per *covered person*;
3. For *medically necessary* genetic blood tests;
4. For *medically necessary* immunizations to prevent respiratory syncytial virus (RSV);
5. For two mastectomy bras per year if the *covered person* has undergone a covered mastectomy;
6. For rental of a standard hospital bed, a standard walker, a standard non-motorized wheelchair, a wheelchair cushion, and a ventilator;
7. For the cost of one Continuous Passive Motion (CPM) machine per *covered person* following a covered joint surgery;
8. For the cost of one wig per *covered person* necessitated by hair loss due to cancer treatments or traumatic burns. See the Schedule of Benefits for benefit levels or additional limits;
9. For occupational therapy following a covered treatment for traumatic hand injuries; and
10. For one pair of eyeglasses or contact lenses per *covered person* following a covered cataract surgery. See the Schedule of Benefits for benefit levels or additional limits.
11. Coverage for hearing aids for a child under the age of 18 who is covered under this policy if the hearing aids are fitted and dispensed by a licensed audiologist or licensed hearing aid specialist following medical clearance by a physician licensed to practice medicine and an audiological evaluation medically appropriate to the age of the child.

Osteoporosis
We cover scientifically proven bone mass measurement for the diagnosis and treatment of osteoporosis as follows:
a) An estrogen-deficient woman at clinical risk of osteoporosis who is considering treatment;
b) An individual receiving long-term steroid therapy;
c) An individual being monitored to assess the response to or efficacy of approved osteoporosis drug therapies.

See the Schedule of Benefit for benefit levels or additional limits.

Outpatient Prescription Drug Expense Benefits
Covered expenses in this benefit subsection are limited to charges from a licensed *pharmacy* for:
1. A *prescription drug; and*
2. Any drug that, under the applicable state law, may be dispensed only upon the written prescription of a *physician.*

See the Schedule of Benefits for benefit levels or additional limits.

The appropriate drug choice for a *covered person* is a determination that is best made by the *covered person* and his or her *physician.*

We will cover prescription drugs to *you* at the contracted benefit level and until *your* renewal date any prescription drug that was approved or covered under the plan for a medical condition or medical illness, regardless of whether the drug has been removed from the health benefit plan's drug formulary before the plan renewal date. However, a physician or other authorized prescriber may prescribe a drug that is an alternative to a drug for which continuation of coverage is required if the alternative drug meets each of the following conditions: (1) The drug is covered under the health benefit plan and (2) The drug is medically appropriate for the enrollee.

Sales Tax Or Interest Including Sales Tax On Prescription Drugs. Any applicable sales tax imposed on Prescription Drugs will be included in the cost of the Prescription Drugs in determining the *coinsurance percentage* and o*ur* financial responsibility. *We* will cover the cost of sales tax imposed on eligible Prescription Drugs, unless the total Prescription Drug Cost is less than the *your deductible amount*, in which case, *you* must pay the Prescription Drug cost and sales tax.

Notice And Proof Of Loss:
In order to obtain payment for *covered expenses* incurred at a *pharmacy* for *prescription orders,* a notice of claim and *proof of loss* must be submitted directly to *us.*

Exclusions And Limitations:
No benefits will be paid under this benefit subsection for expenses incurred:

1. For *prescription drugs* for the treatment of erectile dysfunction or any enhancement of sexual performance;
2. For immunization agents;
3. For medication that is to be taken by the *covered person,* in whole or in part, at the place where it is dispensed;
4. For medication received while the *covered person* is a patient at an institution that has a facility for dispensing pharmaceuticals;
5. For a refill dispensed more than 12 months from the date of a *physician's* order;
6. Due to a *covered person's* addiction to, or dependency on foods;
7. For more than the predetermined *managed drug limitations* assigned to certain drugs or classification of drugs;
8. For a *prescription order* that is available in over-the-counter form, or comprised of components that are available in over-the-counter form, and is therapeutically equivalent, except for over-the-counter products that are covered on the formulary;
9. For drugs labeled "Caution - limited by federal law to investigational use" or for investigational or experimental drugs;
10. For a *prescription drug* that contains an active ingredient(s) that is/are:
    a. Available in and *therapeutically equivalent* to another covered *prescription drug;* or
    b. A modified version of and *therapeutically equivalent* to another covered *prescription drug.* Such determinations may be made up to six times during a calendar year, and *we* may decide at any time to reinstate benefits for a *prescription drug* that was previously excluded under this paragraph;
11. For more than a 34-day supply when dispensed in any one prescription or refill, a 90-day supply when dispensed by mail order;
12. In excess of the cost of the generic equivalent, if any, regardless of whether the *physician* specifies name brand on the written prescription; and
13. For *prescription drugs* for any *covered person* who enrolls in Medicare Part D as of the date of his or her enrollment in Medicare Part D. *Prescription drug* coverage may not be reinstated at a later date.

Pediatric Oral Expense Benefits
Covered expenses in this benefit subsection include the following for an *eligible child* under the age of 19 who is a *covered person*:

1. Diagnostic, preventive and restorative care;
2. Oral surgery and reconstruction;

3. Endodontic and periodontic care;
4. Crown and fixed bridge;
5. Removable prosthetics;
6. *Medically necessary* orthodontia.
7. Prosthodontic Services; and
8. Palliative treatment of dental pain.

Visit limitations are as follows:

1. One diagnostic exam every six months, beginning before age one;
2. Routine Bitewing x-rays once every six months;
3. Panoramic x-rays once every three years;
4. Prophylaxis every six months beginning at age six months;
5. Fluoride three times in a twelve-month period for ages six and under; two times in a twelve-month period for ages seven and older; three times in a twelve-month period during orthodontic treatment; sealant once every three years for occlusal surfaces only; oral hygiene instruction two times in twelve months for ages eight and under if not billed on the same day as a prophylaxis treatment;
6. Every two years for the same restoration;
7. Frenulectomy or frenuloplasty covered for ages six and under without prior authorization;
8. Root canals on baby primary posterior teeth only; Root canals on permanent anterior, bicuspid and molar teeth, excluding teeth 1, 16, 17 and 32;
9. Periodontal scaling and root planing once per quadrant in a two-year period, with prior authorization;
10. Periodontal maintenance once per quadrant in a twelve-month period, with prior authorization;
11. Stainless steel crowns for permanent posterior teeth once every three years;
12. Metal/porcelain crowns and porcelain crowns on anterior teeth only, with prior authorization;
13. Space maintainers for missing molars;
14. One resin based partial denture, replaced once within a three-year period;
15. One complete denture upper and lower, and one replacement denture per lifetime after at least five years from the seat date; and
16. Rebasing and relining of complete or partial dentures once in a three-year period, if performed at least six months from the seating date.

Pediatric Vision Expense Benefits

Covered expenses in this benefit subsection include the following for an *eligible child* under the age of 19 who is a *covered person*:

1. Routine vision screening, including dilation and with refraction every calendar year, including dilation;
2. One pair of prescription lenses or contacts every calendar year, including polycarbonate lenses and scratch resistant coating;
3. One pair of frames very calendar year;
4. Medically Necessary Contact Lenses - Those for treatment of patients affected by certain conditions- Karatoconus, Pathological Myopia, Aphakia, Anisometropia, Aniseikonia, Aniridia, Corneal Disorders, Post-traumatic Disorders, Irregular Astigmatism

Contact lenses are medically necessary when the use of contact lenses, in lieu of eyeglasses, will result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression.

5. Low vision optical devices including low vision services, and an aid allowance with follow-up care when pre-authorized.

Covered expenses do not include:

1. Visual therapy; or
2. Two pair of glasses as a substitute for bifocals.

Preventive Care Expense Benefits

Covered expenses are expanded to include the charges incurred by a *covered person* for the following preventive health services if appropriate for that *covered person* in accordance with the following recommendations and guidelines:

1. Evidence based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force;
2. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to an individual;
3. Evidence-informed preventive care and screenings for infants, children, and adolescents, in accordance with comprehensive guidelines supported by the Health Resources and Services Administration; and
4. Additional preventive care and screenings not included in (1) above, in accordance with comprehensive guidelines supported by the Health Resources and Services Administration for women.
5. Mammograms for women as follows:
    a. One baseline mammogram for any woman who is 35 - 39 years of age.
    b. One mammogram every 24 months for any woman who is 40 - 49 years of age, or more frequently if recommended by her physician.
    c. One mammogram every 12 months for any woman who is 50 years of age or older.
6. Annual Pap tests for cervical cancer and the minimum mammography examination when rendered or prescribed by a physician or other appropriate health care provider licensed in this state and received in any licensed hospital or in any other licensed public or private facility, or portion thereof, including but not limited to clinics and mobile screening units.
7. Coverage for detection of prostate cancer, including digital rectal examination and prostate-specific antigen testing for men over the age of fifty years and as medically necessary and appropriate for men over the age of forty years.

Benefits for preventive health services listed in this provision, except under the administration of reasonable medical management techniques discussed in the next paragraph, are exempt from any deductibles and coinsurance provisions under the *policy* when the services are provided by a *network provider.*

Benefits for *covered expenses* for preventive care expense benefits may include the use of reasonable medical management techniques authorized by federal law to promote the use of high value preventive services from *network providers*. Reasonable medical management techniques may result in the application of deductibles and coinsurance provisions to services when a *covered person* chooses not to use a high

value service that is otherwise exempt from deductibles and coinsurance provisions when received from a *network provider*.

As new recommendations and guidelines are issued, those services will be considered *covered expenses* when required by the United States Secretary of Health and Human Services, but not earlier than one year after the recommendation or guideline is issued.

Newborns' And Mothers' Health Protection Act Statement Of Rights
If expenses for *hospital* confinement in connection with childbirth are otherwise included as *covered expenses*, *we* will not limit the number of days for these expenses to less than that stated in this provision.

Under federal law, health insurance issuers generally may not restrict benefits otherwise provided for any *hospital* length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a delivery by cesarean section. However, *we* may provide benefits for *covered expenses* incurred for a shorter stay if the attending provider (e.g., *your physician*, nurse midwife or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

The level of benefits and out-of-pocket costs for any later part of the 48-hour or 96-hour stay will not be less favorable to the mother or newborn than any earlier part of the stay. *We* do not require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours or 96 hours.

Note: This provision does not amend the *policy* to restrict any terms, limits, or conditions that may otherwise apply to *covered expenses* for childbirth.

Transplant Service Expense Benefits
Covered expenses for transplant expenses:
If *we* determine that a *covered person* is an appropriate candidate for a *listed transplant,* Medical Benefits *covered expenses* will be provided for:

1. Pre-transplant evaluation;
2. Pre-transplant harvesting;
3. Pre-transplant stabilization, meaning an *inpatient* stay to medically stabilize a *covered person* to prepare for a later transplant, whether or not the transplant occurs;
4. High dose chemotherapy;
5. Peripheral stem cell collection;
6. The transplant itself, not including the acquisition cost for the organ or bone marrow except at a *Center of Excellence*; and
7. Post transplant follow-up.

Transplant Donor Expenses:
We will cover the medical expenses incurred by a live donor as if they were medical expenses of the *covered person* if:

1. They would otherwise be considered *covered expenses* under the *policy;*
2. The *covered person* received an organ or bone marrow of the live donor; and
3. The transplant was a *listed transplant.*

Ancillary "Center Of Excellence" Benefits:
A *covered person* may obtain services in connection with a *listed transplant* from any *physician*. However, if a *listed transplant* is performed in a *Center of Excellence:*

1. *Covered expenses* for the *listed transplant* will include the acquisition cost of the organ or bone marrow; and
2. *We* will pay a maximum of $10,000 per lifetime for the following services:
    a. Transportation for the *covered person,* any live donor, and the *immediate family* to accompany the *covered person* to and from the *Center of Excellence.*
    b. Lodging at or near the *Center of Excellence* for any live donor and the *immediate family* accompanying the *covered person* while the *covered person* is confined in the *Center of Excellence. We* will pay the costs directly for transportation and lodging, however, *you* must make the arrangements.

Exclusions:
No benefits will be paid under these Transplant Expense Benefits for charges:

1. For search and testing in order to locate a suitable donor;
2. For a prophylactic bone marrow harvest or peripheral blood stem cell collection when no *listed transplant* occurs;
3. For animal to human transplants;
4. For artificial or mechanical devices designed to replace a human organ temporarily or permanently;
5. For procurement or transportation of the organ or tissue, unless expressly provided for in this provision;
6. To keep a donor alive for the transplant operation;
7. For a live donor where the live donor is receiving a transplanted organ to replace the donated organ;
8. Related to transplants not included under this provision as a *listed transplant; and*
9. For a *listed transplant* under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration (*USFDA*) regulation, regardless of whether the trial is subject to *USFDA* oversight.

Limitations on Transplant Expenses Benefits:
In addition to the exclusions and limitations specified elsewhere in this section:

1. *Covered expenses* for *listed transplants* will be limited to two transplants during any 10- year period for each *covered person*;
2. If a designated *Center of Excellence* is not used, *covered expenses* for a *listed transplant* will be limited to a maximum for all expenses associated with the transplant. See the Schedule of Benefits for benefit levels or additional limits; and
3. If a designated *Center of Excellence* is not used, the acquisition cost for the organ or bone marrow is not covered.

PRIOR AUTHORIZATION

Prior Authorization Required
Some *covered expenses* require prior authorization. In general, *network providers* must obtain authorization from *us* prior to providing a service or supply to a *covered person.* However, there are some *network eligible expenses* for which *you* must obtain the prior authorization.

For services or supplies that require prior authorization*you* must obtain authorization from *us* before the *covered person:*

1. Receives a service or supply from a *non-network provider;*
2. Is admitted into a *network* facility by a *non-network provider;* or
3. Receives a service or supply from a *non-network provider* to which the *covered person* was referred by a *network provider.*

The following services or supplies require prior authorization:

1. *Hospital confinement*s;
2. *Hospital confinement* as the result of a *medical emergency;*
3. *Hospital confinement* for *psychiatric care;*
4. *Outpatient surgeries* and *major diagnostic tests*;
5. *All inpatient services;*
6. *Extended care facility* confinements;
7. *Rehabilitation facility* confinements;
8. *Skilled nursing facility* confinements;
9. *Transplants;* and
10. Chemotherapy, *specialty drugs* and biotech medications.

Except for *medical emergencies*, prior authorization must be obtained before services are rendered or expenses are *incurred*

How To Obtain Prior Authorization
To obtain prior authorization or to confirm that a *network provider* has obtained prior authorization, contact *us* by telephone at the telephone number listed on *your* health insurance identification card before the service or supply is provided to the *covered person.*

Failure To Obtain Prior Authorization
Failure to comply with the prior authorization requirements will result in benefits being reduced. Please see the *policy* Schedule of Benefits for specific details.

There is a penalty if treatment is not authorized prior to service. The penalty is a 20% reduction of the eligible expenses for all charges related to the treatment. The penalty applies to all otherwise eligible expenses that are:

- Incurred for treatment without prior authorization;
- Incurred during additional *hospital* days without prior authorization; or
- Determined to be inappropriately authorized following a retrospective review, or inappropriately authorized due to misrepresentation of facts or false statements.

Network providers cannot bill *you* for services for which they fail to obtain prior authorization as required.

Benefits will not be reduced for failure to comply with prior authorization requirements prior to an *emergency.* However, *you* must contact *us* as soon as reasonably possible after the *emergency* occurs.

Prior Authorization Does Not Guarantee Benefits
Our authorization does not guarantee either payment of benefits or the amount of benefits. Eligibility for, and payment of, benefits are subject to all terms and conditions of the *policy.*

Requests For Predeterminations
You may request a predetermination of coverage. *We* will provide one if circumstances allow *us* to do so. However, *we* are not required to make a predetermination of either coverage or benefits for any particular treatment or medical expense. Any predetermination *we* may make will be reviewed after the medical expense is incurred and a claim is filed. A review that shows one or more of the following may cause *us* to reverse the predetermination:

1. The predetermination was based on incomplete or inaccurate information initially received by *us;*
2. The medical expense has already been paid by someone else; and
3. Another party is responsible for payment of the medical expense.

We will make all benefit determinations after a *loss* in good faith. All benefit determinations are subject to *our* receipt of proper *proof of loss.*

GENERAL LIMITATIONS AND EXCLUSIONS

No benefits will be paid for:

1. Any service or supply that would be provided without cost to *you* or *your* covered *dependent* in the absence of insurance covering the charge;
2. Expenses/surcharges imposed on *you* or *your* covered *dependent* by a provider, including a *hospital*, but that are actually the responsibility of the provider to pay;
3. Any services performed by a member of a *covered person's immediate family; and*
4. Any services not identified and included as *covered expenses* under the *policy*. *You* will be fully responsible for payment for any services that are not *covered expenses.*

Even if not specifically excluded by this *policy,* no benefit will be paid for a service or supply unless it is:

1. Administered or ordered by a *physician;* and
2. *Medically necessary* to the diagnosis or treatment of an *injury* or *illness,* or covered under the Preventive Care Expense Benefits provision.

Covered expenses will not include, and no benefits will be paid for any charges that are incurred:

1. For services or supplies that are provided prior to the *effective date* or after the termination date of this *policy*, except as expressly provided for under the Benefits After Coverage Terminates clause in this *policy's* Termination section;
2. For any portion of the charges that are in excess of the *eligible expense;*
3. For weight modification, or for surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass *surgery*;
4. For breast reduction or augmentation;
5. For modification of the physical body in order to improve the psychological, mental, or emotional well-being of the *covered person,* such as sex-change *surgery*;
6. For the reversal of sterilization and vasectomies;
7. For abortion unless the life of the mother would be endangered if the fetus were carried to term.
8. For treatment of malocclusions, disorders of the temporomandibular joint, or craniomandibular disorders, except as described in *covered expenses* of the Medical Benefits provision;
9. For expenses for television, telephone, or expenses for other persons;
10. For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions;
11. For telephone consultations or for failure to keep a scheduled appointment;
12. For *hospital* room and board and nursing services for the first Friday or Saturday of an *inpatient* stay that begins on one of those days, unless it is an *emergency*, or *medically necessary inpatient surgery* is scheduled for the day after the date of admission;
13. For stand-by availability of a *medical practitioner* when no treatment is rendered;
14. For *dental expenses,* including braces for any medical or dental condition, *surgery* and treatment for oral *surgery*, except as expressly provided for under Medical Benefits;
15. For *cosmetic treatment*, except for *reconstructive surgery* that is incidental to or follows *surgery* or an *injury* that was covered under the *policy* or is performed to correct a birth defect in a child who has been a *covered person* from its birth until the date *surgery* is performed;
16. For diagnosis or treatment of learning disabilities, attitudinal disorders, or disciplinary problems.
17. For diagnosis or treatment of nicotine addiction;
18. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under the Transplant Expense Benefits;

19. For high dose chemotherapy prior to, in conjunction with, or supported by *ABMT/BMT*, except as specifically provided under the Transplant Expense Benefits;
20. For eye refractive *surgery,* when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism;
21. While confined primarily to receive *rehabilitation, custodial care,* educational care, or nursing services unless expressly provided for by the *policy*;
22. For vocational or recreational therapy, vocational *rehabilitation*, outpatient speech therapy, or occupational therapy, except as expressly provided for in this *policy*;
23. For alternative or complementary medicine using non-orthodox therapeutic practices that do not follow conventional medicine. These include, but are not limited to, wilderness therapy, outdoor therapy, boot camp, equine therapy, and similar programs;
24. For eyeglasses, contact lenses, hearing aids, eye refraction, visual therapy, or for any examination or fitting related to these devices, except as specifically provided under the *policy*;
25. For *experimental or investigational treatment(s)* or *unproven services.* The fact that an *experimental or investigational treatment* or *unproven service* is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be an *experimental or investigational treatment* or *unproven service* for the treatment of that particular condition;
26. For a medical *emergency* while traveling for up to a maximum of 90 consecutive days. If travel extends beyond 90 consecutive days, no coverage is provided for medical *emergencies* for the entire period of travel including the first 90 days;
27. As a result of an *injury* or *illness* arising out of, or in the course of, employment for wage or profit, if the *covered person* is insured, or is required to be insured, by workers' compensation insurance pursuant to applicable state or federal law. If *you* enter into a settlement that waives a *covered person's* right to recover future medical benefits under a workers' compensation law or insurance plan, this exclusion will still apply. In the event that the workers' compensation insurance carrier denies coverage for a *covered person's w*orkers' compensation claim, this exclusion will still apply unless that denial is appealed to the proper governmental agency and the denial is upheld by that agency;
28. As a result of:
    a. Intentionally self-inflicted bodily harm whether the *covered person* is sane or insane;
    b. An *injury* or *illness* caused by any act of declared or undeclared war;
    c. The *covered person* taking part in a riot; or
    d. The *covered person's* commission of or attempt to commit a felony or to which a contributing cause was the *covered person's* being engaged in an illegal occupation.;
29. For or related to *durable medical equipment* or for its fitting, implantation, adjustment, or removal, or for complications there from, except as expressly provided for under the Medical Benefits;
30. For any *illness* or *injury* as a consequence of the *covered person* being intoxicated, or under the influence of illegal narcotics unless administered on the advice of a *physician*;
31. For or related to surrogate parenting;
32. For or related to treatment of hyperhidrosis (excessive sweating);
33. For fetal reduction surgery;
34. Except as specifically identified as a *covered expense* under the *policy*, expenses for alternative treatments, including acupressure, acupuncture, aroma therapy, hypnotism, other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health and when not performed by a licensed Chiropractor practicing within the scope of his license, massage therapy and rolfing;

35. As a result of any *injury* sustained during or due to participating, instructing, demonstrating, guiding, or accompanying others in any of the following: operating or riding on a motorcycle; professional or semi-professional sports; intercollegiate sports not including intramural sports; parachute jumping; hang-gliding; racing or speed testing any motorized vehicle or conveyance; racing or speed testing any non-motorized vehicle or conveyance, if the *covered person* is paid to participate or to instruct; scuba/skin diving when diving 60 or more feet in depth; skydiving; bungee jumping; rodeo sports; horseback riding, if the *covered person* is paid to participate or to instruct; rock or mountain climbing, if the *covered person* is paid to participate or to instruct; or skiing, if the *covered person* is paid to participate or to instruct;
36. As a result of any *injury* sustained while operating, riding in, or descending from any type of aircraft if the *covered person* is a pilot, officer, or member of the crew of such aircraft or is giving or receiving any kind of training or instructions or otherwise has any duties that require him or her to be aboard the aircraft;
37. As a result of any *injury* sustained while at a *residential treatment facility;*
38. For prescription drugs for any *covered person* who enrolls in Medicare Part D as of the date of his or her enrollment in Medicare Part D. Prescription drug coverage may not be reinstated at a later date; and
39. For the following miscellaneous items: artificial Insemination except where required by federal or state law; biofeedback; care or complications resulting from non-*covered expenses*; chelating agents; domiciliary care; food and food supplements; routine foot care, foot orthotics or corrective shoes; health club memberships, unless otherwise covered; home test kits; care or services provided to a non-*member* biological parent; nutrition or dietary supplements; pre-marital lab work; processing fees; private duty nursing; rehabilitation services for the enhancement of job, athletic or recreational performance; routine or elective care outside the service area; sclerotherapy for varicose veins; treatment of spider veins; smoking cessation drugs, programs or services, except where required by federal or state law; transportation expenses, unless specifically described in this *policy*;
40. Services or supplies eligible for payment under either federal or state programs (except Medicaid). This exclusion applies whether or not *you* assert *your* rights to obtain this coverage or payment of these services.

Limitation On Benefits For Services Provided By Medicare Opt-Out Practitioners
Benefits for *covered expenses* incurred by a Medicare-eligible individual for services and supplies provided by a *Medicare opt-out practitioner* will be determined as if the services and supplies had been provided by a *Medicare participating practitioner*. Benefits will be determined as if Medicare had, in fact, paid the benefits it would have paid if the services and supplies had been provided by a *Medicare participating practitioner*.

TERMINATION

Termination Of Policy
All insurance will cease on termination of this *policy.* This *policy* will terminate on the earliest of:

1. Nonpayment of premiums when due, subject to the Grace Period provision in this *policy*;
2. The date *we* receive a request from *you* to terminate this *policy,* or any later date stated in *your* request;
3. The date *we* decline to renew this *policy,* as stated in the Discontinuance provision;
4. The date of *your* death, if this *policy* is an Individual Plan;
5. The date that a *covered person* accepts any direct or indirect contribution or reimbursement through wage adjustment or otherwise, by or on behalf of an employer for any portion of the premium for coverage under this *policy,* or the date a *covered person's* employer and a *covered person* treat this *policy* as part of an employer-provided health plan for any purpose, including tax purposes;
6. The date a *covered person's* eligibility for insurance under this *policy* ceases due to losing network access as the result of a permanent move; or
7. The date a *covered person's* eligibility for insurance under this *policy* ceases due to any of the reasons stated in the Ongoing Eligibility section in this *policy*.

We will refund any premium paid and not earned due to *policy* termination.

If this *policy* is other than an Individual Plan, it may be continued after *your* death:

1. By *your spouse*, if a *covered person;* otherwise
2. By the youngest child who is a *covered person.*

This *policy* will be changed to a plan appropriate, as determined by *us,* to the *covered person(s)* that continue to be covered under it. *Your spouse* or youngest child will replace *you* as the primary covered person. A proper adjustment will be made in the premium required for this *policy* to be continued. *We* will also refund any premium paid and not earned due to *your* death. The refund will be based on the number of full months that remain to the next premium due date.

Discontinuance
90-Day Notice:
If *we* discontinue offering and refuse to renew all policies issued on this form, with the same type and level of benefits, for all residents of the state where *you* reside, *we* will provide a written notice to *you* at least 90 days prior to the date that *we* discontinue coverage. *You* will be offered an option to purchase any other coverage in the individual market *we* offer in *your* state at the time of discontinuance of this *policy*. This option to purchase other coverage will be on a guaranteed issue basis without regard to health status.

180-Day Notice:
If *we* discontinue offering and refuse to renew all individual policies/certificates in the individual market in the state where *you* reside, *we* will provide a written notice to *you* and the Commissioner of Insurance at least 180 days prior to the date that *we* stop offering and terminate all existing individual policies in the individual market in the state where *you* reside.

Portability Of Coverage
If a person ceases to be a *covered person* due to the fact that the person no longer meets the definition of *dependent* under the *policy*, the person will be eligible for continuation of coverage. If elected, *we* will continue the person's coverage under the *policy* by issuing an individual policy. The premium rate applicable to the new policy will be determined based on the residence of the person continuing coverage. All other terms and conditions of the new policy, as applicable to that person, will be the same as this *policy*, subject to any applicable requirements of the state in which that person resides. Any *deductible amounts* and maximum benefit limits will be satisfied under the new policy to the extent satisfied under this *policy* at the time that the continuation of coverage is issued. If the original coverage contains a family deductible which must be met by all *covered persons* combined, only those expenses incurred by the *covered person* continuing coverage under the new policy will be applied toward the satisfaction of the *deductible amount* under the new policy.

Notification Requirements
It is the responsibility of *you* or *your* former *dependent* to notify *us* within 31 days of *your* legal divorce or *your dependent's* marriage. *You* must notify *us* of the address at which their continuation of coverage should be issued.

Continuation of Coverage
We will issue the continuation of coverage:
1. No less than 30 days prior to a *covered person's* 26th birthday; or
2. Within 30 days after the date *we* receive timely notice of *your* legal divorce or *dependent's* marriage. *Your* former *dependent* must pay the required premium within 31 days following notice from *us* or the new *policy* will be void from its beginning.

Reinstatement
If any premium is not paid by the end of the grace period *your* coverage will terminate. Later acceptance of premium by *us*, within four calendar days of the end of the grace period, will reinstate *your policy* with no break in *your* coverage. *We* will refund any premium that *we* receive after this four-day period.

Reinstatement shall not change any provisions of the *policy*.

Benefits After Coverage Terminates
Benefits for *covered expenses* incurred after a *covered person* ceases to be insured are provided for certain *illnesses* and *injuries.* However, no benefits are provided if this *policy* is terminated because of:
1. A request by *you*;
2. Fraud or material misrepresentation on *your* part; or
3. *Your* failure to pay premiums.

The *illness* or *injury* must cause a *period of extended loss,* as defined below. The *period of extended loss* must begin before insurance of the *covered person* ceases under this *policy*. No benefits are provided for *covered expenses* incurred after the *period of extended loss* ends.

In addition to the above, if this *policy* is terminated because *we* refuse to renew all policies issued on this form, with the same type and level of benefits, to residents of the state where *you* live, termination

of this *policy* will not prejudice a claim for a *continuous loss* that begins before insurance of the *covered person* ceases under this *policy.* In this event, benefits will be extended for that *illness* or *injury* causing the *continuous loss,* but not beyond the earlier of:

1. The date the *continuous loss* ends; or
2. 12 months after the date renewal is declined.

During coverage for a *period of extended loss* or a *continuous loss,* as described above, the terms and conditions of this *policy,* including those stated in the Premiums section of this *policy,* will apply as though insurance had remained in force for that *illness* or *injury*.

Continuity of Care

In the event that a *member* is receiving treatment from a physician or other health care provider and that provider's participation in the plan terminates, except for reason of medical competence or professional behavior, the physician or health care provider shall not be released from the obligation to treat the insured person and cooperate in arranging for appropriate referrals if, at the time of preferred provider termination, the insured has special circumstances, as identified by the treating physician, such as a disability, acute condition, or *life threatening condition* and is receiving treatment in accordance with the dictates of medical prudence. Likewise, for a period of 90 days following termination, we shall not be released from the obligation to reimburse such physician, health care provider or, if applicable, the insured at the same preferred provider rate in the event or termination when such conditions apply. In the event of a diagnosed high-risk pregnancy or a pregnancy that is past the 24th week, a *member* will continue receiving covered health care services through delivery and postpartum care related to the pregnancy.

COORDINATION OF BENEFITS

The Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits.

The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans does not exceed 100% of the total Allowable expense.

DEFINITIONS
A Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

Plan includes: group and nongroup insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law. Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

This plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

The order of benefit determination rules determine whether This plan is a Primary plan or Secondary plan when the person has health care coverage under more than one Plan.

When This plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

Allowable expense is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit

paid. An expense that is not covered by any Plan covering the person is not an Allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable expense.

The following are examples of expenses that are not Allowable expenses:

1. The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.

2. If a person is covered by 2 or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.

3. If a person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.

4. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary plan's payment arrangement shall be the Allowable expense for all Plans. However, if the provider has contracted with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary plan to determine its benefits.

5. The amount of any benefit reduction by the Primary plan because a covered person has failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

Closed panel plan is a Plan that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES
When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.

B. (1) Except as provided in Paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary.

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.

C. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

D. Each Plan determines its order of benefits using the first of the following rules that apply:

(1) Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary plan and the Plan that covers the person as a dependent is the Secondary plan. However, if the person is a Medicare *beneficiary* and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.

(2) Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married: the Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or if both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.
(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
(2) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;

(3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or
(4) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
The Plan covering the Custodial parent;
The Plan covering the spouse of the Custodial parent;
The Plan covering the non-custodial parent; and then
The Plan covering the spouse of the non-custodial parent.

(c) For a dependent child covered under more than one Plan of individuals who are the parents of the child, the provisions (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(3) Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same person as a retired or laid-off employee is the Secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(4) COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(5) Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.

(6) If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, this plan will not pay more than it would have paid had it been the Primary plan.

EFFECT ON THE BENEFITS OF THIS PLAN
When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the amount so that, when

combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim. In addition, the Secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

If a covered person is enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed panel plan, COB shall not apply between that Plan and other Closed panel plans.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION
Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This plan and other Plans. Organization responsibility for COB administration may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This plan and other Plans covering the person claiming benefits. Organization responsibility for COB administration need not tell, or get the consent of, any person to do this. Each person claiming benefits under This plan must give Organization responsibility for COB administration any facts it needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT
A payment made under another Plan may include an amount that should have been paid under this plan. If it does, Organization responsibility for COB administration may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan. Organization responsibility for COB administration will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY
If the amount of the payments made by Organization responsibility for COB administration is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

REIMBURSEMENT

If a *covered person's illness* or *injury* is caused by the acts or omissions of a *third party*, *we* will not cover a *loss* to the extent that it is paid as part of a settlement or judgment by any *third party*.

However, if payment by or for the *third party* has not been made by the time *we* receive acceptable *proof of loss, we* will pay regular *policy* benefits for the *covered person's loss*. *We* will have the right to be reimbursed to the extent of benefits *we* paid for the *illness* or *injury* if the *covered person* subsequently receives any payment from any *third party*. The *covered person* or the guardian, legal representatives, estate, or heirs of the *covered person* shall promptly reimburse *us* from the settlement, judgment, or any payment received from any *third party*. *We* agree to pay *our* portion of *your* attorneys' fee or other costs associated with a claim or lawsuit to the extent that *we* recover any portion of the benefits paid under this policy pursuant to *our* right of reimbursement.

As a condition for *our* payment, the *covered person* or anyone acting on his or her behalf including, but not limited to, the guardian, legal representatives, estate, or heirs agrees:

1. To fully cooperate with *us* in order to obtain information about the *loss* and its cause;
2. To immediately inform *us* in writing of any claim made or lawsuit filed on behalf of a *covered person* in connection with the *loss*;
3. To include the amount of benefits paid by *us* on behalf of a *covered person* in any claim made against any *third party*;
4. That *we*:
    a. Will have a lien on all money received by a *covered person* in connection with the *loss* equal to the amount *we* have paid;
    b. May give notice of that lien to any *third party* or *third party's* agent or representative;
    c. Will have the right to intervene in any suit or legal action to protect *our* rights;
    d. Are subrogated to all of the rights of the *covered person* against any *third party* to the extent of the benefits paid on the *covered person's* behalf; and
    e. May assert that subrogation right independently of the *covered person*;
5. To take no action that prejudices *our* reimbursement and subrogation rights;
6. To sign, date, and deliver to *us* any documents *we* request that protect *our* reimbursement and subrogation rights;
7. To not settle any claim or lawsuit against a *third party* without providing *us* with written notice of the intent to do so;
8. To reimburse *us* from any money received from any *third party*, to the extent of benefits *we* paid for the *illness* or *injury*, whether obtained by settlement, judgment, or otherwise, and whether or not the *third party's* payment is expressly designated as a payment for medical expenses; and
9. That *we* may reduce other benefits under the *policy* by the amounts a *covered person* has agreed to reimburse *us*.

Furthermore, as a condition of *our* payment, *we* may require the *covered person* or the *covered person's* guardian, if the *covered person* is a minor or legally incompetent, to execute a written reimbursement agreement. However, the terms of this provision remain in effect regardless of whether or not an agreement is actually signed.

We agree to pay *our* portion of *your* attorneys' fee or other costs associated with a claim or lawsuit to the extent that *we* recover any portion of the benefits paid under this policy pursuant to *our* right of subrogation.

If a dispute arises as to the amount a *covered person* must reimburse *us*, the *covered person* or the guardian, legal representatives, estate, or heirs of the *covered person* agrees to place sufficient funds in an escrow or trust account to satisfy the maximum lien amount asserted by *us* until the dispute is resolved.

CLAIMS

Notice Of Claim
We must receive notice of claim within 30 days of the date the *loss* began or as soon as reasonably possible.

Proof Of Loss
You or *your* covered *dependent* must give *us* written *proof of loss* within 90 days of the *loss* or as soon as is reasonably possible. *Proof of loss* furnished more than one year late will not be accepted, unless *you* or *your* covered *dependent had no legal capacity in that year.*

Claim Forms
Upon receipt of a notice of claim, we will provide you with forms for filing proofs of loss. If such forms are not furnished within fifteen days after the giving of notice, the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, affirmative written proof covering the occurrence, the character and the extent of the loss for which claim is made.

Uniform Claim Forms
Notwithstanding any other law to the contrary, all claims shall be processed in conformity with the uniform claim form issued by the Louisiana Department of Insurance.

Cooperation Provision
Each *covered person*, or other person acting on his or her behalf, must cooperate fully with *us* to assist *us* in determining *our* rights and obligations under the *policy* and, as often as may be reasonably necessary:

1. Sign, date and deliver to *us* authorizations to obtain any medical or other information, records or documents *we* deem relevant from any person or entity;
2. Obtain and furnish to *us*, or *our* representatives, any medical or other information, records or documents *we* deem relevant;
3. Answer, under oath or otherwise, any questions *we* deem relevant, which *we* or *our* representatives may ask; and
4. Furnish any other information, aid or assistance that *we* may require, including without limitation, assistance in communicating with any person or entity including requesting any person or entity to promptly provide to *us*, or *our* representative, any information, records or documents requested by *us*.

If any *covered person*, or other person acting on his or her behalf, fails to provide any of the items or information requested or to take any action requested, the claim(s) will be closed and no further action will be taken by *us* unless and until the item or information requested is received or the requested action is taken, subject to the terms and conditions of the *policy*.

In addition, failure on the part of any *covered person*, or other person acting on his or her behalf, to provide any of the items or information requested or to take any action requested may result in the denial of claims of all *covered persons*.

Time For Payment Of Claims
Benefits will be paid immediately upon receipt of *proof of loss*. Any nonelectronic claim submitted by a *network provider or its agent* for provision of health care services, within forty-five days of the date of

service, or date of discharge from a health care facility or institution, shall be paid, denied, or pended not more than forty-five days from the date upon which a nonelectronic clean claim is received by *us* unless it is not payable under the terms of the applicable contract of health insurance coverage or unless just and reasonable grounds exist such as would put a reasonable and prudent businessman on his guard. Any nonelectronic claim submitted by a *network provider or its agent* for provision of health care services, within forty-five days of the date of service, or date of discharge from a health care facility or institution, more than forty-five days after the date of service, or date of discharge from a health care facility or institution, or resubmitted because the original claim was not an accepted claim or not a clean claim shall be paid, denied, or pended not more than sixty days from the date upon which a nonelectronic clean claim is received by *us* unless it is not payable under the terms of the applicable contract of insurance or unless just and reasonable grounds exist such as would put a reasonable and prudent businessman on his guard. Any other nonelectronic claim for health insurance coverage benefits submitted for payment by a *covered person* or a *non-network provider* rendering covered health care services, or by the provider's agent, shall be paid, denied, or pended not more than forty-five days from the date upon which a nonelectronic clean claim is received by *us*, unless it is not payable under the terms of the applicable contract of insurance or unless just and reasonable grounds exist such as would put a reasonable and prudent businessman on his guard.

Any electronic claim shall be paid, denied, or pended not more than twenty-five days from the date upon which an electronic clean claim is electronically received by *us*, unless it is not payable under the terms of the applicable contract of insurance or unless just and reasonable grounds exist such as would put a reasonable and prudent businessman on his guard.

We shall either provide written notice to the provider that a claim is pended or allow the provider Internet access to such information.

We shall have the same prescribed period of time following payment of such claim to perform any review or audit for purposes of reconsidering the validity of such claim.

Payment Of Claims

Except as set forth in this provision, all benefits are payable to *you.* Any accrued benefits unpaid at *your* death, or *your dependent's* death may, at *our* option, be paid either to the *beneficiary* or to the estate. If any benefit is payable to *your* or *your dependent's* estate, or to a *beneficiary* who is a minor or is otherwise not competent to give valid release, *we* may pay up to $1,000 to any relative who, in *our* opinion, is entitled to it.

We may pay all or any part of the benefits provided by this *policy* for *hospital,* surgical, nursing, or medical services, directly to the *hospital* or other person rendering such services.

Claims for emergency services provided by a n*on-network provider* shall be paid directly to the *non-network provider* in the amount as determined by the policy provisions less any amount representing *coinsurance*, *deductibles*, non-covered services, or any other amounts identified by us pursuant to the policy provisions, as an amount for which the covered person is liable. Payment of such claim shall in no circumstances be made directly to the covered person.

Any payment made by *us* in good faith under this provision shall fully discharge *our* obligation to the extent of the payment. *We* reserve the right to deduct any overpayment made under this *policy* from any future benefits under this *policy*.

Foreign Claims Incurred For Emergency Care
Claims incurred outside of the United States for *emergency* care and treatment of a *covered person* must be submitted in English or with an English translation. Foreign claims must include the applicable medical records in English to show proper *proof of loss*.

Assignment
We will reimburse a *hospital* or health care provider if:
1. *Your* health insurance benefits are assigned by *you* in writing; and
2. *We* approve the assignment.

Any assignment to a *hospital* or person providing the treatment, whether with or without *our* approval, shall not confer upon such *hospital* or person, any right or privilege granted to *you* under the *policy* except for the right to receive benefits, if any, that *we* have determined to be due and payable.

Consent Of Beneficiary
Consent of the *beneficiary* will not be required for the surrender or assignment of this policy, nor for change of *beneficiary*, nor for any other changes in this policy.

Medicaid Reimbursement
The amount payable under this *policy* will not be changed or limited for reason of a *covered person* being eligible for coverage under the Medicaid program of the state in which he or she lives.

We will pay the benefits of this *policy* to the state if:
1. A *covered person* is eligible for coverage under his or her state's Medicaid program; and
2. *We* receive proper *proof of loss* and notice that payment has been made for *covered expenses* under that program.

Our payment to the state will be limited to the amount payable under this *policy* for the *covered expenses* for which reimbursement is due. Payment under this provision will be made in good faith. It will satisfy *our* responsibility to the extent of that payment.

Insurance With Other Insurers
If there is other valid coverage providing benefits on a provision of service or an expense incurred basis and of which *we* have not been given written notice prior to the occurrence or commencement of loss, our only liability under this policy shall be for a proportion of the loss as the amount which would otherwise have been payable plus the total of the like amounts under all such other valid coverages for the same loss of which We had notice bears to the total like amounts under all valid coverages. *We* shall return any portion of the premiums paid that exceeds the pro-rata portion of the amount so determined. For the purpose of applying this provision when other coverage is on a provision of service basis, the "like amount" of such other coverage shall be taken as the amount which the services rendered would have cost in the absence of such coverage.

Other valid coverage shall not include group insurance, automobile medical payments insurance, or coverage provided by hospital or medical service organizations or by union welfare plans or employer or employee benefit organizations or any third party liability coverage.

Insurance With Medicare
If a person is also a Medicare *beneficiary*, Medicare is always the primary plan. This means that benefits paid for *eligible expenses* by *your* plan will be reduced by the amount that Medicare pays.

Custodial Parent
This provision applies if the parents of a covered *eligible child* are divorced or legally separated and both the custodial parent and the non-custodial parent are subject to the same court or administrative order establishing custody. The custodial parent, who is not a *covered person*, will have the rights stated below if *we* receive a copy of the order establishing custody.

Upon request by the custodial parent, *we* will:
1. Provide the custodial parent with information regarding the terms, conditions, benefits, exclusions and limitations of the *policy*;
2. Accept claim forms and requests for claim payment from the custodial parent; and
3. Make claim payments directly to the custodial parent for claims submitted by the custodial parent. Payment of claims to the custodial parent, which are made under this provision, will fully discharge *our* obligations.

A custodial parent may, with *our* approval, assign claim payments to the *hospital* or *medical practitioner* providing treatment to an *eligible child*.

Physical Examination
We shall have the right and opportunity to examine the *covered person* when and as often as it may reasonably require during the pendency of a claim and to make an autopsy in case of death where it is not forbidden by law.

Legal Actions
No suit may be brought by *you* on a claim sooner than 60 days after the required *proof of loss* is given. No suit may be brought more than three years after the date *proof of loss* is required.

No action at law or in equity may be brought against *us* under the *policy* for any reason unless the *covered person* first completes all the steps in the complaint/grievance procedures made available to resolve disputes in *your* state under the *policy*. After completing that complaint/grievance procedures process, if *you* want to bring legal action against *us* on that dispute, *you* must do so within three years of the date *we* notified *you* of the final decision on *your* complaint/grievance.

GRIEVANCE AND COMPLAINT PROCEDURES

INTERNAL PROCEDURES

Applicability/Eligibility
The internal *grievance* procedures apply to any hospital or medical policy or certificate or conversion plans, but not to accident only or disability only insurance.

An Eligible grievant is:

1. A claimant*;*
2. *P*erson authorized to act on behalf of the claimant. **Note:** Written authorization is not required; however, if received, we will accept any written expression of authorization without requiring specific form, language, or format;
3. In the event the claimant is unable to give consent: a spouse, family member, or the treating Provider; or
4. In the event of an *expedited grievance*: the person for whom the insured has verbally given authorization to represent the claimant.
   Important: *Adverse benefit determinations* that are not *grievances* will follow standard PPACA internal appeals processes.

Grievances
Claimants have the right to submit written comments, documents, records, and other information relating to the claim for benefits. Claimants have the right to review the claim file and to present evidence and testimony as part of the internal review process.

Grievances will be promptly investigated and presented to the internal *grievance* panel. A plan that is providing benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review. The plan is required to provide continued coverage pending the outcome of an appeal.

Resolution Timeframes

1. *Grievances* regarding quality of care, quality of service, or *reformation* will be resolved within 30 calendar days of receipt. The time period may be extended for an additional 30 calendar days, making the maximum time for the entire *grievance* process 60 calendar days if *we* provide the *claimant* and the *claimant's* authorized representative, if applicable, written notification of the following within the first 30 calendar days:
   a. That *we* have not resolved the *grievance*;
   b. When *our* resolution of the *grievance* may be expected; and
   c. The reason why the additional time is needed.
2. All other *grievances* will be resolved and *we* will notify the *claimant* in writing with the appeal decision within the following timeframes:
   a. ***Post-service claim***: within 60 calendar days after receipt of the *claimant*'s request for internal appeal;
   b. ***Pre-service claim***: within 30 calendar days after receipt of the *claimant*'s request for internal appeal.

A claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. All comments, documents, records and other information submitted by the claimant relating to the claim for benefits, regardless of whether such information was submitted or considered in the initial *adverse benefit determination*, will be considered in the internal appeal.

1. The claimant will receive from the plan, as soon as possible, any new or additional evidence considered by the reviewer. The plan will give the claimant 10 calendar days to respond to the new information before making a determination, unless the state turnaround time for response is due in less than 10 days. If the state turnaround time is less than 10 days, the claimant will have the option of delaying the determination for a reasonable period of time to respond to the new information;
2. The claimant will receive from the plan, as soon as possible, any new or additional medical rationale considered by the reviewer. The plan will give the claimant 10 calendar days to respond to the new medical rationale before making a determination, unless the state turnaround time for response is due in less than 10 days. If the state turnaround time is less than 10 days, the claimant will have the option of delaying the determination for a reasonable period of time to respond to the new medical rationale.

Refer to a later section for information regarding internal *expedited grievances*.

Acknowledgement
Within five business days of receipt of a *grievance*, a written acknowledgment to the claimant or the claimant's authorized representative confirming receipt of the *grievance* must be delivered or deposited in the mail.

When acknowledging a *grievance* filed by an authorized representative, the acknowledgement shall include a clear and prominent notice that health care information or medical records may be disclosed only if permitted by law.

1. The acknowledgement shall state that unless otherwise permitted under applicable law, informed consent is required and the acknowledgement shall include an informed consent form for that purpose;
2. If such disclosure is prohibited by law, health care information or medical records may be withheld from an authorized representative, including information contained in its resolution of the *grievance*; and
3. A *grievance* submitted by an authorized representative will be processed regardless of whether health care information or medical records may be disclosed to the authorized representative under applicable law.

Right to Appear
The claimant who filed the *grievance*, or the claimant's authorized representative, has the right to appear in person before the *grievance* panel to present written or oral information. The grievant may submit written questions to the person or persons responsible for making the determination that resulted in the *grievance*.

1. Written notification must be sent to the claimant indicating the time and place of the *grievance* panel meeting at least seven calendar days before the meeting;
2. Reasonable accommodations must be provided to allow the claimant, or the claimant's authorized representative, to participate in the *grievance* panel.

Grievance Panel
The *grievance* panel will not include the person who made the initial determination and is not the subordinate of the original reviewer. The panel may, however, consult with the initial decision-maker. If the panel consists of at least three persons, the panel may then include no more than one subordinate of the person who made the initial determination.

The *grievance* panel will include:
1. At least one individual authorized to take corrective action on the *grievance*; and
2. At least one insured other than the grievant, if an insured is available to serve on the *grievance* panel. The insured member of the panel shall not be an employee of the plan, to the extent possible.

When the *adverse benefit determination* is based in whole or in part on a medical judgment, the *grievance* panel will consult with a licensed health care provider with expertise in the field relating to the *grievance* and who was not consulted in connection with the original *adverse benefit determination*.

Expedited Grievance
An *expedited grievance* may be submitted orally or in writing. All necessary information, including *our* determination on review, will be transmitted between the claimant and *us* by telephone, facsimile, or other available similarly expeditious method.

An *expedited grievance* shall be resolved as expeditiously as the *claimant*'s health condition requires but not more than 72 hours after receipt of the *grievance*.

Due to the 72-hour resolution timeframe, the standard requirements for notification, *grievance* panel/right to appear, and acknowledgement do not apply to *expedited grievances*.

Upon written request, *we* will mail or electronically mail a copy of the claimant's complete policy to the claimant or the claimant's authorized representative as expeditiously as the *grievance* is handled.

Written Grievance Response
Grievance response letters shall describe, in detail, the *grievance* procedure and the notification shall include the specific reason for the denial, determination or initiation of disenrollment.
The panel's written decision to the grievant must include:
1. The disposition of and the specific reason or reasons for the decision;
2. Any corrective action taken on the *grievance*;
3. The signature of one voting member of the panel; and
4. A written description of position titles of panel members involved in making the decision.
5. If upheld or partially upheld, it is also necessary to include:
    a. A clear explanation of the decision;
    b. Reference to the specific plan provision on which the determination is based;
    c. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant 's claim for benefits.
    d. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was

relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;

e. If the *adverse benefit determination* is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant 's medical circumstances, or a statement that such explanation will be provided free of charge upon request.;
f. Identification of medical experts whose advice was obtained on behalf of the health plan, without regard to whether the advice was relied upon in making the *adverse benefit determination*;
g. The date of service;
h. The health care provider's name;
i. The claim amount;
j. The diagnosis and procedure codes with their corresponding meanings, or an explanation that the diagnosis and/or procedure codes are available upon request;
k. The health plan's denial code with corresponding meaning;
l. A description of any standard used, if any, in denying the claim;
m. A description of the external review procedures, if applicable;
n. The right to bring a civil action under state or federal law;
o. A copy of the form that authorizes the health plan to disclose protected health information, if applicable;
p. That assistance is available by contacting the specific state's consumer assistance department, if applicable; and
q. A culturally linguistic statement based upon the claimant's county or state of residence that provides for oral translation of the *adverse benefit determination*, if applicable.

Complaints

Basic elements of a *complaint* include:

1. The complainant is the claimant or an authorized representative of the claimant;
2. The submission may or may not be in writing;
3. The issue may refer to any dissatisfaction about:
    a. Us, as the insurer; e.g., customer service *complaints* - "the person to whom I spoke on the phone was rude to me";
    b. Providers with whom *we* have a direct or indirect contract;
        i. Lack of availability and/or accessibility of network providers not tied to an unresolved benefit denial; and
        ii. Quality of care/quality of service issues;
4. Written expressions of dissatisfaction regarding quality of care/quality of service are processed as *grievances*.
5. Oral expressions of dissatisfaction regarding quality of care/quality of service are processed as *complaints* as indicated in standard oral *complaint* instructions; and
6. Any of the issues listed as part of the definition of *grievance* received from the *claimant* or the claimant's authorized representative where the caller has not submitted a written request but calls us to escalate their dissatisfaction and request a verbal/oral review.

Complaints received from the State Insurance Department
The commissioner may require *us* to treat and process any *complaint* received by the State Insurance Department by, or on behalf of, a claimant as a *grievance* as appropriate. *We* will process the State Insurance Department *complaint* as a *grievance* when the commissioner provides *us* with a written description of the *complaint*.

External Review
An external review decision is binding on *us*. An external review decision is binding on the claimant except to the extent the claimant has other remedies available under applicable federal or state law.
We will pay for the costs of the external review performed by the independent reviewer.

Applicability/Eligibility
The G*rievance* procedures apply to:
1. Any hospital or medical policy or certificate; excluding accident only or disability income only insurance; or
2. Conversion plans.

After exhausting the internal review process, the claimant has four months to make a written request to the Grievance Administrator for external review after the date of receipt of *our* internal response.
1. The internal appeal process must be exhausted before the claimant may request an external review unless the claimant files a request for an expedited external review at the same time as an internal *expedited grievance* or *we* either provide a waiver of this requirement or fail to follow the appeal process;
2. A health plan must allow a claimant to make a request for an expedited external review with the plan at the time the claimant receives:
    a. An *adverse benefit determination* if the determination involves a medical condition of the claimant for which the timeframe for completion of an internal *expedited grievance* would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an internal *expedited grievance*; and
    b. A final internal *adverse benefit determination*, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the final internal *adverse benefit determination* concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility; and
3. Claimants may request an expedited external review at the same time the internal *expedited grievance* is requested and an Independent Review Organization (IRO) will determine if the internal *expedited grievance* needs to be completed before proceeding with the expedited external review.

External review is available for *grievances* that involve:
1. Medical judgment, including but not limited to those based upon requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit; or the determination that a treatment is experimental or investigational, as determined by an external reviewer; or
2. *Rescissions* of coverage.

External Review Process

1. We have five business days (immediately for expedited) following receipt of the request to conduct a preliminary review of the request to determine whether:
    a. The individual was a covered person at the time the item or service was requested;
    b. The service is a covered service under the claimant's health plan but for the plan's *adverse benefit determination* with regard to medical necessity experimental/investigational, medical judgment, or *rescission*;
    c. The claimant has exhausted the internal process; and
    d. The claimant has provided all of the information required to process an external review.
2. Within one business day (immediately for expedited) after completion of the preliminary review, we will notify the claimant in writing as to whether the request is complete but not eligible for external review and the reasons for its ineligibility or , if the request is not complete, the additional information needed to make the request complete;
3. We must allow a claimant to perfect the request for external review within the four-month filing period or within the 48-hour period following the receipt of notification;
4. We will assign an IRO on a rotating basis from our list of contracted IROs;
5. Within five business days after the date of assignment of the IRO, we must provide the documents and any information considered in making the *adverse benefit determination* to the IRO.
   Note: For expedited, after assignment of the IRO, we must provide the documents and any information considered in making the *adverse benefit determination* to the IRO electronically or by telephone or facsimile or any other available expeditious method;
6. If we fail to timely provide the documents and information, the IRO may terminate the external review and make a decision to reverse the *adverse benefit determination*;
7. Within 10 business days, the assigned IRO will timely notify the claimant in writing of the request's eligibility and acceptance for external review. The notice will include a statement that the claimant may submit in writing additional information to the IRO to consider;
8. Upon receipt of any information submitted by the claimant, the IRO must forward the information to us within one business day;
9. Upon receipt of the information, we may reconsider our determination. If we reverse our *adverse benefit determination*, we must provide written notice of the decision to the claimant and the IRO within one business day after making such decision. The external review would be considered terminated;
10. Within 45 days (72 hours for expedited) after the date of receipt of the request for an external review by the health plan, the IRO will review all of the information and provide written notice of its decision to uphold or reverse the *adverse benefit determination* to the claimant and to us. If the notice for an expedited review is not in writing, the IRO must provide written confirmation within 48 hours after the date of providing the notice;
11. Upon receipt of a notice of a decision by the IRO reversing the *adverse benefit determination*, we will approve the covered benefit that was the subject of the *adverse benefit determination*.

GENERAL PROVISIONS

Entire Contract
This *policy,* with the application and any rider-amendments is the entire contract between *you* and *us.* No change in this *policy* will be valid unless it is approved by one of *our* officers and noted on or attached to this *policy.* No agent may:

1. Change this *policy*;
2. Waive any of the provisions of this *policy*;
3. Extend the time for payment of premiums; or
4. Waive any of *our* rights or requirements.

Non-Waiver
If *we* or *you* fail to enforce or to insist on strict compliance with any of the terms, conditions, limitations or exclusions of the *policy*, that will not be considered a waiver of any rights under the *policy*. A past failure to strictly enforce the *policy* will not be a waiver of any rights in the future, even in the same situation or set of facts.

Rescissions
No misrepresentation of fact made regarding a *covered person* during the application process that relates to insurability will be used to void/rescind the insurance coverage or deny a claim unless:

1. The misrepresented fact is contained in a written application, including amendments, signed by a *covered person;*
2. A copy of the application, and any amendments, has been furnished to the *covered person(s),* or to their *beneficiary*; and
3. The misrepresentation of fact was intentionally made and material to *our* determination to issue coverage to any *covered person.* A *covered person's* coverage will be voided/rescinded and claims denied if that person performs an act or practice that constitutes fraud. “Rescind” has a retroactive effect and means the coverage was never in effect.

Repayment For Fraud, Misrepresentation Or False Information
During the first two years a *covered person* is insured under the *policy*, if a *covered person* commits fraud, misrepresentation or knowingly provides false information relating to the eligibility of any *covered person* under this *policy* or in filing a claim for *policy* benefits, *we* have the right to demand that *covered person* pay back to *us* all benefits that *we* paid during the time the *covered person* was insured under the *policy*.

Conformity With State Laws
Any part of this *policy* in conflict with the laws of the state in which your policy was issued on this *policy's effective date* or on any premium due date is changed to conform to the minimum requirements of that state's laws.